MEDICARE SUPPLEMENT INSURANCE POLICIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

MARCH 13, 1990

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MEDICARE SUPPLEMENT INSURANCE POLICIES

Tuesday, March 13, 1990

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:11 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
TUESDAY, MARCH 6, 1990

PRESS RELEASE #20
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
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THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON
MEDICARE-SUPPLEMENT INSURANCE POLICIES

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on Medicare-supplement insurance policies. The hearing will be held on Tuesday, March 13, 1990, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said: "Last year, the Congress repealed the Medicare Catastrophic Coverage Act -- a program designed to protect seniors against the rising cost of medical care. Without comprehensive coverage under the Medicare program, the majority of seniors will continue to purchase and rely upon Medigap insurance to cover deductibles, coinsurance and additional benefits. This hearing will take a broad look at the Medigap market."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

Private Medicare-supplement insurance policies, known commonly as Medigap, are designed to supplement the Medicare program. Medigap policies generally cover deductibles and copayments, and often cover additional benefits not covered by the Medicare program, such as outpatient prescription drugs.

While regulation of insurance is currently a State responsibility, beginning in the mid-1970's the National Association of Insurance Commissioners (NAIC) developed model standards for Medicare-supplement policies for use by individual States.

In 1980, the Congress enacted minimum Federal standards for Medigap policies in response to reports of abuses in the Medigap market (P.L. 96-265). This provision, also known as the "Baucus Amendment," created a voluntary certification process and was based upon the NAIC's 1979 model standards.

The "Baucus Amendment" provides loss ratio requirements for group and individual policies and criminal penalties for certain abusive sales practices. The 1980 law does not apply to Medigap plans offered by employers or labor organizations, to policies for specific diseases, or to hospital indemnity policies.

The NAIC model standards have been revised several times in the past decade. In 1980, the NAIC amended its model standards to incorporate changes made by Congress in P.L. 96-265. The NAIC model standards were revised in 1988 to conform to changes made in the Medicare Catastrophic Coverage Act and were revised again in 1989 after the Act was repealed.

(MORE)

Despite numerous changes in the NAIC model standards, there is some concern about the value of Medigap policies sold on the market today. According to the U.S. General Accounting Office, for one third of commercial companies, loss ratios for individual policies were below the minimum standard of 60 percent. For group plans, two thirds of commercial companies and one quarter of Blue Cross and/or Blue Shield plans had loss ratios below the minimum standard of 75 percent.

Other concerns include the sale of duplicate policies, the sale of policies to Medicaid beneficiaries, widespread confusion among consumers and marketing abuses.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Thursday, March 30, 1990, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman STARK. The Health Subcommittee will begin a hearing to examine the so-called medigap market, a topic important to four out of five senior citizens who own one or more private insurance policies to supplement their Medicare coverage, commonly referred to as medigap. There have been numerous reports of abusive sales practices and worthless products in this market.

Yesterday, I introduced H.R. 4242, the Medigap Reform Act of 1990, to make improvements in the marketing and quality of medigap policies.

This bill would set minimum quality standards for private health insurance policies sold to older Americans. Basically, that refers to minimum loss ratios, the amount of money seniors get back relative to the amount of premium dollars they put in.

The current regulatory structure with State regulation and minimal Federal guidelines established under the Baucus amendments of 1980, allows companies to sell substandard policies and to continue to use unscrupulous sales practices in many States.

The GAO reports that fully a third of the commercial companies operate below the National Association of Insurance Commissioners minimum loss ratio standard for individual policies. In other words, one-third of the commercial companies pay out less than 60 cents in benefits for every $1 premium received from elderly customers. In these cases, issuers of medigap policies spend more than 40 cents of every consumer's insurance dollar for sales commissions, overhead and profit.

I think it's important to point out that of the small group and of individual policies, 70 percent would meet the new requirements, and of large groups almost 90 percent would meet these requirements. There is definitely a case here of several apples spoiling the barrel, but they are very big apples.

Medigap premiums for comprehensive policies run as high as $1,200 a year, and they are on their way up, thereby forcing seniors to make fundamental sacrifices to purchase complete protection.

Loss ratio standards, if enforced, will help assure seniors a fair return on their premium dollar.

The secondary objective of this bill is to help elderly consumers make informed purchasing decisions to simplify and standardize the benefits so that a senior reviewing policies, or indeed a less senior person reviewing policies for his or her mother, can make an intelligent and informed decision as to the relative value of policies offering the same benefits.

We know how complicated the insurance market can be, even for educated consumers. Most policies have meaningless differences and unnecessary complications, and they should be eliminated.

Under provisions of this bill, the benefits covered would be described with uniform language. Policies would be permitted but not required to cover a limited number of additional benefits.

The third objective is to eliminate unnecessary and redundant insurance coverage, perhaps the worst abuse of insurance in this country.

According to the American Association of Retired Persons, 24 percent of the seniors with medigap insurance have two or more

policies. Even the Health Insurance Association of American admitted that 15 percent of policyowners have two or more policies.

More troubling is the extent of medigap sales to individuals in the Medicaid program. According to the AARP, 51 percent of Medicaid beneficiaries also purchase medigap insurance, by definition redundant coverage.

The Medigap Reform Act would prohibit any sale of a medigap policy to an owner of another policy or to an individual enrolled in Medicaid.

Finally, the bill would eliminate the future sale of hospital indemnity and dread disease policies to senior citizens.

You will hear testimony today that indemnity policies provide a great addition to the way of life of seniors who are struck with disease, or whose spouse may be committed to a hospital. If somebody wants additional income in the event of an illness, there are two States in this country, the great State of New Jersey and the great State of Nevada, that would offer you better terms at the blackjack tables than you can get from most of these indemnity policies. I would urge those who would suggest their parents need this kind of a gamble to go to States where it's legal.

The Federal Government has responsibilities to establish and enforce meaningful standards. After all, the medigap industry was developed as a response to the Medicare program and the lapses in coverage which it now has.

We would establish minimum standards in a Federal enforcement mechanism to be sure the standards are maintained. We would enforce this legislation through a tax on noncomplying policies.

There have been numerous suggestions that the penalties in this bill for noncompliance are too weak. It would be my intention to toughen or increase the penalties when this bill is marked up to thwart any temptation to sidestep these minimum standards by simply paying an increased tax and continuing to gouge the public.

There has not been a comprehensive Federal initiative to reform the medigap market since the Baucus amendments of 1980. While that bill began to set standards for the market, we know too well that abuses persist.

I would suggest that the witnesses this morning have a challenge. It has never been this committee's intention to "fix something that isn't broke," the beneficiaries of catastrophic health insurance notwithstanding.

There are lousy policies and poor sales practices in this country. Present law does not prohibit that. Ninety percent of the group companies would not be affected, no State would be affected or hindered in its regulation. I think it would be incumbent for one who doesn't like the law to point out what harm it could possibly do to a company or a salesperson who is selling a reasonable and efficient product in a responsible manner.

I doubt that that case can be made, but the purpose of the hearing is to give everybody a chance to make it. The State regulators have enjoyed a complete absence of Federal regulations since, most likely, the founding of the Republic.

I think, with the mobility of the American public, there is nothing wrong with a Federal standard that will ensure for those

people who may move from New York to Florida part of the year, that they will have the same standards in a policy purchased in Florida as in New York.

There is nothing wrong in protecting my mother or your father from unscrupulous sales practices that provide redundant coverage which is totally useless. There's particularly nothing wrong with it if there are laws that prohibit it.

Voluntary compliance doesn't work very well on the freeways, for those of you who may happen to drive 55 miles an hour know, and I think the time has come in a modern society with a growing need for increased insurance coverage because of growing medical costs, that the Federal Government provide minimum standards and a minimum amount of protection to the consumers.

Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman. I will be very brief.

I just want to thank you for raising before our subcommittee this important subject. I think after the repeal of the catastrophic health insurance law, there is no question that there is a great deal of confusion on the part of those persons covered by Medicare and the consumers of private health insurance for coverage of the gaps in Medicare coverage.

I believe that while I don't know that I am prepared to endorse your bill, I am certainly prepared to say that I do think that there is a problem. We need to carefully consider that while we want to make sure that consumers are given their moneys worth in what they buy in the way of insurance, we, at the same time, want to make sure that that insurance can continue to be available on a competitive basis with as little restraint on the free trade as possible.

So, Mr. Chairman, thank you for this opportunity to participate in these hearings and discuss this important subject.

Chairman STARK. Mr. Coyne, Mr. Levin.

[No reply.]

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Yes. I also want to thank the chairman for holding these hearings and for holding them with the input of NAIC.

I think we are in a position to address the very real problems of consumer confusion, duplicate coverage and poor value. Having struggled through choosing medigap coverage with my own mother and seen the number of policies that she ended up buying, I firmly and deeply believe that there are serious problems in this sector. I hope that the witnesses will address themselves, not only to the issue of uniform format and language, but uniform benefit requirements.

I believe that we have to get a policy out there that is so precisely equivalent that there will be no question in the minds of our seniors about what policy will give them the greatest values. Many of these seniors are women who have never dealt with insurance policies before, and whose husbands did that for them. They are particularly vulnerable in this arena.

I think it is our job to assure that there is a basic benefit package and then, above that, other policies that add different coverage. But I think the hearing today is addressing a real problem, the

squandering of the limited resources of many of our seniors, most of whom live on limited incomes.

Thank you, Mr. Chairman.

Chairman STARK. Thank you, Mrs. Johnson.

Our first witness this morning is Janet Shikles, the Director for Health Financing and Policy Issues in the Human Resources Division of the U.S. General Accounting Office.

Welcome back to the committee, Ms. Shikles. If you would, please introduce the gentleman accompanying you for the clerk. Your testimony will be made a part of the record in its entirety.

I would like you to summarize it or expand on it, or enlighten us in any manner that you're comfortable.

STATEMENT OF JANET L. SHIKLES, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY THOMAS DOWDAL, ASSISTANT DIRECTOR, MEDICARE

Ms. SHIKLES. Thank you. I would like to introduce Tom Dowdal, who is our Assistant Director for our Medicare work at the General Accounting Office.

Chairman STARK. Could I also admonish all of the witnesses to come as close as they possibly can to the microphone. It will be easier for our guests and the stenographer and the members to hear you. It's necessary. Thanks very much.

Ms. SHIKLES. We are very pleased to be here today to discuss the work we're been doing at the subcommittee's request on Medicare supplemental or medigap insurance. Today, we will be discussing 1990 medigap premium increases and the percentage of premiums paid out as benefits, the loss ratios, in 1988. We will also discuss possible changes to Federal medigap standards that could increase consumer protection and improve the economic value of medigap policies.

During the debate surrounding the repeal of the Catastrophic Act, concerns were raised in the Congress about the effect that the repeal would have on medigap premiums, and how the additional premium increases would affect low-income elderly persons.

After the Catastrophic Act was repealed, we contacted 29 commercial medigap insurers to get estimates of their 1990 premium increases and the reasons for the premium change. Twenty companies responded to our survey request, representing policies sold to about 2.6 million policyholders. These companies estimated their 1990 premiums will, on average, will be 19.5 percent higher than premiums in 1989. The average increase is $11.44 per month, and the range is from 5 to 51 percent. One company said that it would not be raising its premium. The companies attributed about half the expected premium increases to general inflation within the medical sector of the economy, increased use of health services by the elderly, and higher than expected claims experience in prior years. The other half of the increase they attributed to the repeal of the Catastrophic Act.

The Blue Cross and Blue Shield Association also surveyed its member organizations. Thirty-eight organizations responded, representing about two-thirds of the total Blue Cross and Blue Shield

medigap enrollment. After summarizing the responses, the association found that the median increase in 1990 non-group-medigap insurance premiums would be about 29 percent.

In addition to the issue of increasing premiums from medigap insurance, another congressional concern has been the portion of medigap premiums returned to policyholders in the form of benefits or loss ratios. We have obtained 1988 loss ratio data which are the latest available, for medigap insurance from NAIC and Blue Cross and Blue Shield. These aggregate data measure a company's overall performance because they average experience across all policies.

Our analysis shows that many company loss ratios are still not meeting the minimum standards. In 1988, the loss ratios for companies with policies in force 3 years or more, were based on total earned premiums of approximately $3.7 billion. For policies sold to individuals by commercial insurers, 34 percent of the company loss ratios were below the 60-percent minimum standard. Among the Blue Cross and Blue Shield plans, for the individual policies, 98 percent met or exceeded the target loss ratio percentage.

For group coverage, about 66 percent of the commercial company loss ratios were below the 75-percent minimum standard. Among the Blue Cross and Blue Shield group plans, about 24 percent had loss ratios that fell below the minimum standard.

You also asked that we identify changes that could be made to the Baucus amendment to improve the economic value of medigap policies for beneficiaries, to assist beneficiaries when they are considering purchasing a medigap policy, and to increase consumer protection.

We have several suggestions for the subcommittee to consider. The first would be to require medigap policies to meet the loss ratio standards. The Baucus amendment requires that policies be expected to meet the loss ratio standards stated in the provision. The latest NAIC model regulation requires that policies in effect for 3 years or more actually meet the loss ratio standards. Amending the Baucus amendment to make it consistent with the NAIC model would remove any doubt that the Congress intends that policies meet the standards.

The second suggestion is to raise the minimum loss ratios. Our analysis found that, in 1988, about two-thirds of the premium dollars for individual policies in force for 3 years or more were for policies with loss ratios of 80 percent or higher.

About 86 percent of the premium dollars for group policies in force for 3 years or more, were for policies with loss ratios of 85 percent or higher. This indicates that if the loss ratio standards were raised to the 80- to 85-percent range, medigap policies would continue to be widely available to beneficiaries.

Increasing the minimum acceptable loss ratios would mainly affect those insurers with high levels of profits and/or marketing costs. These companies would have to accept lower profits, reduce marketing costs, or leave the business.

Third, require States to review advertising materials for medigap policies. This would make advertising review consistent across the States, and would help assure that the elderly are not exposed to deceptive or misleading medigap advertising materials.

Fourth, encourage the States to operate a consumer counseling service. Of the 12 States that we visited in our work for this subcommittee, 4 had some type of consumer counseling service relying on insurance department or Office of Aging employees or volunteers to help the elderly assess their medigap needs and the options available.

Finally, require uniform medigap policies. Currently, medigap policies must meet minimum benefit levels. However, companies offer many combinations of benefits in addition to the minimums. This makes it difficult for consumers to comparison shop for the best price because policies offered by two different companies may have different benefit structures as well as different premiums. The Baucus amendment could be changed to require that only certain benefits be offered and that they be offered only in certain combinations.

The advantage of this proposal is that consumers could comparison shop among companies on the basis of price and service, knowing that the products are comparable. The disadvantage is that it does limit consumer choice to the approved levels of benefits and benefit combinations.

Mr. Chairman, this concludes my prepared remarks, and I would be happy to answer any questions.

[The statement of Ms. Shikles follows:]

TESTIMONY OF JANET L. SHIKLES, DIRECTOR
HEALTH FINANCING AND POLICY ISSUES, HUMAN RESOURCES DIVISION
U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the work we have been doing at the Subcommittee's request on Medicare supplemental (or Medigap) insurance. We will be discussing 1990 Medigap premium increases, the percentage of premiums paid out as benefits (the loss ratios) in 1988 and recent changes in federal and state regulatory requirements for Medigap policies. As you requested, we will also discuss posible changes to federal Medigap standards that could increase consumer protection and improve the economic value of Medigap policies.

MCCA AND ITS REPEAL

The Medicare Catastrophic Coverage Act (MCCA), which became law in July 1988, provided for the most significant expansion of Medicare benefits since the program's beginning. Beneficiary out-of-pocket costs for covered services were to be capped, and additional services would have been covered when the law was fully implemented.

In June and April 1989, we testified before committees of both houses of the Congress on the effects of MCCA on benefits provided by the Medicare program and Medigap insurance[1]. In both instances, we noted that MCCA expanded Medicare benefits and thus reduced the coverages required of Medigap policies. We pointed out that a number of major benefits provided under MCCA would become effective in 1990, and we expected that Medigap premiums for 1990 would be substantially lower than they would have been without MCCA.

In November 1989, the Congress passed legislation to repeal MCCA and to restore Medicare benefits to what they were before the Act became effective. The repeal legislation reversed the reduction in coverage required of Medigap policies, and we expected this would result in significantly higher Medigap premiums than if MCCA had remained in effect.

PREMIUMS FOR MEDIGAP INSURANCE
AFTER REPEAL OF MCCA

During the debate surrounding the repeal of MCCA, concerns were raised in the Congress about the effect repeal would have on Medigap premiums and how the additional premium increases would affect low-income elderly persons. At your request, Mr. Chairman, we took a look at these issues. We contacted 29 commercial Medigap insurers to obtain (1) their estimate of their 1990 premiums and (2) their reasons for premium changes. The results of that survey were reported to you in November 1989.[2] At that time, the Medigap insurers estimated that their 1990 premiums would be an average of 15.4 percent higher than their 1989 premiums.

After the Congress repealed MCCA, we again contacted those 29 commercial Medigap insurers to get updated estimates. Twenty companies responded to that request and are listed in appendix I to this statement. The policies sold by those 20 companies covered about 2.6 million policyholders, and they estimate their

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[1]See "MEDIGAP INSURANCE: Effects of the Catastrophic Coverage Act of 1988 on Future Benefits", Statement of Mr. Michael Zimmerman before the Senate Committee on Finance (GAO/T-HRD-89-22, June 1, 1989) and "MEDIGAP INSURANCE: Effects of the Catastrophic Coverage Act of 1988 on Benefits and Premiums", Statement of Mr. Michael Zimmerman before the Subcommittee on Commerce, Consumer Protection, and Competitiveness, House Committee on Energy and Commerce (GAO/T-HRD-89-13, Apr. 6, 1989).

[2]See Medicare Catastrophic Act: Estimated Effects of Repeal on Medigap Premiums and Medicaid Costs (GAO/HRD-90-48FS, Nov. 6, 1989).

1990 premiums will, on average, be 19.5 percent higher than premiums in 1989. The average increase is $11.44 per month. The increases range from 5.0 percent to 51.6 percent, and one company reported that it expected its 1990 premium to be the same as its 1989 premium. Appendix II to this statement shows the estimates from the twenty companies.

The companies attributed about half of the expected premium increases to general inflation within the medical sector of the economy, increased use of health services by the elderly, and higher than expected claims experience in prior years. The companies attributed the other half of the increase to repeal of MCCA. The companies said that changes required by repeal of MCCA included: (1) additions to benefits, such as coverage of the part A deductible or reducing the policy deductible for part B coinsurance coverage from $200 to $75, and (2) administrative costs associated with repeal of the MCCA, such as modifications to policies and notices to policyholders.

The Blue Cross and Blue Shield Association also surveyed its member organizations. Thirty-eight organizations responded, representing two-thirds of the total Blue Cross and Blue Shield Medigap enrollment. After summarizing the responses, the Association found that the median increase in 1990 non-group Medigap insurance premiums would be about 29 percent. Had MCCA remained in force, the Association projected that premiums would rise by about 9 percent. The Association attributed plan rate increases to numerous factors, including growth in costs and utilization, benefit changes, and adjustments for prior rate inadequacies.

MEDIGAP LOSS RATIOS FOR 1988

In addition to concerns about increasing premiums for Medigap insurance, another congressional concern has been the portion of Medigap premiums returned to policyholders in the form of benefits, or the policies' loss ratios. A loss ratio is computed by dividing total incurred claims[3] by total earned premiums for the same period. The result of this computation is usually expressed as a percentage.

The Baucus amendment, which amended the Medicare law to establish federal Medigap standards, set loss ratio targets for Medigap policies. The Baucus amendment established expected loss ratios for Medigap policies -- at least 75 percent for group policies and at least 60 percent for individual policies. MCCA revised the Baucus amendment to require states to collect data on actual Medigap loss ratios.

In an earlier GAO report[4] and congressional hearings, we reported on the loss ratios of Medigap policies. Generally, we have reported that pre-1988 loss ratios of most commercial policies were below the minimum standards. In contrast, the pre-1988 loss ratios of Blue Cross and Blue Shield plans were generally above the standards. For example, in our 1986 report, we said that the 1984 average loss ratio for individual policies sold by 92 commercial firms was 60 percent; for policies sold by 13 Blue Cross and Blue Shield plans, the average was 81 percent. In 1989, we reported that the 1987 average loss ratio for 92 commercial policies was 74 percent; however, that average was heavily influenced by the relatively large block of business

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[3]Incurred claims include actual payments for claims plus reserves for claims incurred but not yet received or processed by the insurer.

[4]Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies (GAO/HRD-87-8, Oct. 17, 1986).

represented by the Prudential Insurance Company, whose loss ratio was 83 percent. Excluding Prudential, the other commercial policies had an average loss ratio of 59 percent. For 75 Blue Cross and Blue Shield plans, the 1987 average loss ratio on individual plans was 93 percent. Because of changes in loss ratio reporting requirements discussed below, these pre-1988 loss ratios cannot be directly compared with more current loss ratio information.

Some caution is needed in the interpretation and use of loss ratio data because a number of factors may affect the computations. For example, early policy experience may result in a relatively low loss ratio because policies do not cover costs related to pre-existing conditions during the policy's waiting period. Also, new policyholders may be relatively healthy and file few claims, so a policy with substantial amounts of new business may experience a relatively low loss ratio. Thus, a policy's loss ratio should be viewed over the time that represents "mature" experience. For years prior to 1988, the National Association of Insurance Commissioners' (NAIC) form used by insurers to report Medigap loss ratio data included the reporting year's experience for all policies in force and a cumulative report of the 3 most current years' experience. Beginning with reports covering 1988 and later, the NAIC provides a two-tiered set of criteria for determining if loss ratios comply with loss ratio standards:[5]

-- For policies that have been in force 3 years or more, the most recent year's loss ratio must equal or exceed the 60 or 75 percent standard (whichever is applicable).

-- For policies that have been in force less than 3 years, the policies must have a third-year expected loss ratio equal to or greater than the 60 or 75 percent standard.

We have obtained 1988 loss ratio data (the latest available) for Medigap insurance from NAIC[6] and the Blue Cross and Blue Shield Association. The data are reported in aggregate for all policies sold by a company. These aggregate data measure a company's overall performance because they average experience across all policies. This means that a company whose aggregate loss ratio is below the standards has one or more policies which fail to meet the minimum standards but may have other policies that meet or exceed the standards. Conversely, a company can have an aggregate loss ratio above the standards but have some policies that fall below them.

The aggregate loss ratios by companies for policies in force 3 years or more with more than $250,000 in earned premiums are summarized in appendices III and IV. Similar data for policies that have been in force for less than 3 years are in appendices V and VI.

Many company loss ratios are still not meeting the minimum standards. In 1988, the loss ratios for companies with policies in force 3 years or more were based on total earned premiums of approximately $3.7 billion. For policies sold to individuals:

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[5]In addition, the NAIC has revised the formula for determining the incurred claims portion of the loss ratio. Prior to 1988, incurred claims included actual payments for claims plus reserves for claims incurred but not yet reported to or processed by the company plus a life-time reserve for future claims. For loss ratios covering 1988 and later years, incurred claims no longer include the life-time reserves in the computation.

[6]The NAIC labeled its data "preliminary results only," and these data are subject to change.

-- By commercial insurers, 34 percent of the company loss ratios were below the 60 percent minimum standard. The average loss ratios for companies exceeding the standard was 68.5 percent while the average for companies below the standard was 50 percent. About 88 percent of total earned premiums was with companies whose average loss ratio exceeded the minimum standard.

-- Among the Blue Cross and Blue Shield plans, 98 percent met or exceeded the target loss ratio percentage. The average loss ratio for these plans was 93.4 percent; the loss ratio of the single plan that fell below the standard was 53.9 percent. Over 99 percent of total earned premiums was with plans whose average loss ratio exceeded the minimum standard.

For group coverage:

-- About 66 percent of the commercial company loss ratios were below the 75 percent minimum standard. The average loss ratio for companies that were at or above the target was 101.5 percent, and the average for those below the target was 62.6 percent. About 93 percent of total earned premiums was with plans whose average loss ratio exceeded the minimum standard.

-- Among the Blue Cross and Blue Shield plans, 24 percent had loss ratios that fell below the minimum target. The average loss ratio for plans that met or exceeded the target was 91.4 percent, and the average for those below the target was 71.5 percent. About 88 percent of total earned premiums was with plans whose average loss ratio exceeded the minimum standard.

Earned premiums for policies in force less than 3 years totaled approximately $3.5 billion for 1988. For policies sold to individuals:

-- By commercial insurers, 60 percent of the company loss ratios were below the 60 percent minimum standard.
-- Among the Blue Cross and Blue Shield plans, all met or exceeded the standard.

For group coverage, about 71 percent of the commercial companies and 16 percent of the Blue Cross and Blue Shield plans did not meet the 75 percent target. Additional details are in appendix VI.

Under the Baucus amendment, states are responsible for monitoring whether Medigap policies meet the loss ratio standards and for taking action when they do not. In the past, states did little to assure that the loss ratio targets were met. This was because the loss ratio standards were expressed as targets and the manner in which loss ratio data were reported by insurers did not facilitate monitoring. Under the revised federal and NAIC standards, policies must meet the loss ratio standards after 3 years and the manner in which loss ratios are reported will make such determinations easier than in the past. When the new standards are adopted, the states should be better able to enforce the standards than was the case in the past.

This Subcommittee has already asked us to monitor Medigap loss ratios through 1994.

REGULATORY REQUIREMENTS FOR MEDIGAP POLICIES AFTER REPEAL OF MCCA

Over the years, another congressional concern related to Medigap has been marketing abuses and consumer protection against those abuses. NAIC's most recent revision to its model

regulations, adopted in early December 1989, included several new consumer protection provisions. These new standards have been incorporated under the Baucus amendment as the criteria for approval of state regulatory programs and are now before the states for their consideration and adoption. The new NAIC standards continue efforts, which began with the passage of the Baucus amendment, to eliminate abuses in the sale and marketing of Medigap insurance. We believe that if adopted and enforced by the states, the new provisions will help prevent abuses in the sale of Medigap policies.

One problem in the sale of Medigap insurance that has been identified over the years is that some Medicare beneficiaries purchase multiple policies that duplicate coverage. Revised consumer protection provisions in the NAIC model should help alleviate this problem. Application forms will include questions asking whether the applicant has another Medigap policy in force and, if so, whether the policy being applied for is intended to replace any medical or health insurance already in force. Agents must also list on the application any health insurance policies they have sold to the applicant. The sale of more than one Medigap policy to an individual is prohibited, unless the combined policies' coverages do not exceed 100% of the individual's actual medical expenses. In addition, if the sale involves replacement of a Medigap policy, an insurer or its agent must provide the applicant with a notice before the replacement policy goes into effect that the coverage applied for replaces health insurance in force. This notice will give purchasers an additional opportunity to review their coverage and to cancel the new policy without penalty if they decide not to replace a policy already in force.

Another problem with Medigap marketing has been frequent replacement of policies which results in new waiting periods for pre-existing conditions. Insurance agents had an incentive to sell replacement policies because the sale commission structure gave much higher remuneration for the first year a policy was in effect than for renewal years. New NAIC provisions should decrease the incentives to sell new policies by placing restrictions on the way commissions are paid and prohibiting waiting periods when replacement policies are sold. The compensation provision limits the first-year commission and other compensation[7] that may be paid to an agent selling a Medigap policy and also requires companies to spread the total compensation for selling a policy over a reasonable number of years. These requirements will prevent companies from loading agent compensation into the first years a policy is in effect, thus decreasing the incentive to sell replacement policies. Also, when issuing a replacement Medigap policy, insurers must waive waiting periods applicable to pre-existing conditions or other similar restrictions to the extent such time was spent under the original policy.

In addition to the consumer protection provisions, the new NAIC model regulation modified some minimum benefit standards for Medigap policies from those required before MCCA was enacted. For example:

-- For services covered under part A of Medicare. Current NAIC standards require Medigap policies to cover either all or none of the part A deductible ($592 per benefit period in 1990). The NAIC standard in effect before MCCA did not contain a minimum requirement for coverage of the part A deductible, and thus a policy could have covered just a portion of that deductible.

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[7]Compensation includes bonuses, gifts, prizes, awards, finders fees, and other similar forms of remuneration.

-- For services covered under part B of Medicare. NAIC's current standards require Medigap policies to cover all policyholders' coinsurance for services covered by part B of Medicare, after the policyholder has paid the part B deductible of $75 per year. This coinsurance is 20 percent of the Medicare-approved charge for services. Prior to the MCCA, the NAIC standards required Medigap policies to pay part B coinsurance after the policyholder paid $200 (the $75 annual part B deductible plus $125 in part B coinsurance), and Medigap policies could limit coverage to $5,000 in benefits in any calendar year.

POSSIBLE REVISIONS TO THE BAUCUS AMENDMENT

You asked that we identify changes that could be made to the Baucus amendment to improve the economic value of Medigap policies for beneficiaries, to assist beneficiaries when they are considering purchasing a Medigap policy, and to increase consumer protection. We have several suggestions for the Subcommittee to consider.

Require Medigap policies to meet the loss ratio standards. The Baucus amendment requires that policies be expected to meet the loss ratios stated in the provision. In effect, as long as the insurer estimates that a policy will meet the standard, it has complied with the requirement whether or not its actual loss ratio ever meets the minimum standard. The latest NAIC model regulation requires that policies in effect for 3 years or more actually meet the loss ratio standard. Amending the Baucus amendment to make it consistent with the NAIC model would remove any doubt that the Congress intends that policies meet the standards. Moreover, the revised provisions would make it easier for states to take action on premium rate increase requests because prior experience rather than merely estimated future experience could be factored into the rate approval process.

Raise the minimum loss ratios. To increase the economic value of Medigap policies, the Congress could increase the minimum allowable loss ratios in the Baucus amendment. In 1988, about two-thirds of the premium dollars for individual policies in force for 3 years or more were for policies with loss ratios of 80 percent or more and about 86 percent of the premium dollars for group policies in force for 3 years or more were for policies with loss ratios of 85 percent or more. Also, as I mentioned before, loss ratio data for the Blue Cross and Blue Shield plans have been ,on average, above these levels for a number of years. This indicates that if the loss ratio standards were raised to the 80- to 85-percent range, Medigap policies would continue to be widely available to beneficiaries. Increasing the minimum acceptable loss ratios would mainly affect those insurers with high levels of profits and/or marketing costs. These companies would have to accept lower profits, reduce marketing costs, or leave the business.

Require states to review advertising materials for Medigap policies. As in the case of rate reviews, states have varying advertising review authority.[8] The NAIC says that most states are file and use jurisdictions. Of the 12 states we visited, 1 is a prior approval state and 11 are file and use states. Under

[8]There are three basic types of review authority. Under prior approval authority, insurers are required to submit their advertising for review and may use it after receiving approval from the state. Under file and use authority, insurers must submit their advertising and may use it if it is not disapproved within a stated period of time. Under use and file authority, insurers may begin using their advertising at the same time they submit it for state approval.

current federal law, insurers are required to follow state law regarding submission of their advertising materials for state review. The Congress may wish to require all states to subject advertising material to some level of review before it may be used. This would make advertising review consistent across the states and would help assure that the elderly are not exposed to deceptive or misleading Medigap advertising materials.

Encourage the states to operate a consumer counseling service. Of the 12 states we visited, 4 had some type of consumer counseling service, relying on insurance department or office of aging employees, or volunteers, to help the elderly assess their Medigap needs and the options available. Legislation recently introduced in the Senate would provide grants to states to operate toll-free telephone assistance lines and counseling services for Medicare beneficiaries. This proposal is designed to help increase the availability to the elderly of information on benefits under Medicare, how to shop for Medigap or long-term care insurance, and how to obtain help if they have a problem with their health insurance.

Require uniform Medigap policies. Medigap policies must meet minimum benefit levels, but companies offer many combinations of benefits in addition to the minimums. This makes it difficult for consumers to comparison shop for the best price, because policies offered by two different companies may have different benefit structures as well as different premiums. The Baucus amendment could be changed to require that only certain benefits be offered and that they be offered only in certain combinations. Under such a plan, companies might be limited to, say, four or five different levels and combinations of benefits. Each policy of a particular type from a company would provide the same benefits as policies of that type offered by any other company. The advantage of this proposal is that consumers could comparison shop among companies on the basis of price and service, knowing that the products are comparable. The disadvantages of this proposal are that it limits consumer choice to the approved levels of benefits and benefit combinations and precludes insurers from experimenting with new benefit packages.

Mr. Chairman, this concludes my prepared remarks. I will be happy to answer any questions you have.

APPENDIX I

APPENDIX I

INSURANCE COMPANIES THAT RESPONDED TO OUR REQUEST FOR DATA

Prudential Insurance Company of America
United American Insurance
Bankers Life
Mutual of Omaha
Union Fidelity Life Insurance Company
National Home Life Assurance Company
Union Bankers Insurance Company
Standard Life and Accident Insurance Company
The Principal Mutual Life Insurance Company
Pioneer Life Insurance Company of Illinois
Pyramid Life Insurance Company
Associated Doctors Health and Life Insurance Company
Colonial Penn Franklin
State Farm Mutual Auto Insurance Company
Continental Casualty Company
American Integrity Insurance Company
New York Life Insurance Company
Provident Companies
American Republic
Atlantic American Life Insurance Company

APPENDIX II

APPENDIX II

EXPECTED INCREASES IN 1990 MONTHLY MEDIGAP INSURANCE PREMIUMS AFTER REPEAL OF THE MEDICARE CATASTROPHIC COVERAGE ACT

Company	1989 monthly premium	1990 expected monthly premium	Increase (percentage)
Company AA	$50.00	$50.00	0.0
Company AB	83.09	87.26	5.0
Company AC	59.93	65.32	9.0
Company AD	73.96	81.29	9.9
Company AE	73.46	80.79	10.0
Company AF	61.65	70.15	13.8
Company AG	68.00	78.00	14.7
Company AH	81.00	94.00	16.0
Company AI	39.25	45.95	17.1
Company AJ	58.75	70.39	19.8
Company AK	68.00	81.52	19.9
Company AL	33.90	41.00	20.9
Company AM	57.65	70.33	22.0
Company AN	38.00	46.36	22.0
Company AO	43.29	53.68	24.0
Company AP	90.00	115.00	27.8
Company AQ	50.82	67.59	33.0
Company AR	43.84	59.67	36.1
Company AS	62.82	90.93	44.7
Company AT	32.95	49.95	51.6
Average	$58.52	$69.96	19.5

DISTRIBUTION OF 1988 MEDIGAP LOSS RATIOS
FOR POLICIES THAT HAVE BEEN IN FORCE FOR 3 YEARS OR MORE

For policies sold to individuals,
with more than $250,000 in earned premiums

Commercial plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 40%	4	$ 7,666	31.8
40 - 49%	12	40,786	46.5
50 - 59%	28	52,179	55.4
Sub-total	44	$100,631	50.0
60 - 69%	38	$520,946	64.3
70 - 79%	22	76,570	74.8
80 - 89%	16	61,326	83.2
90 - 99%	9	29,332	91.9
100% or more	2	1,617	116.7
Sub-total	87	$689,791	68.5

Blue Cross/Blue Shield plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 40%			
40 - 49%			
50 - 59%	1	$527	53.9
Sub-total	1	$527	53.9
60 - 69%	3	$ 68,904	65.7
70 - 79%	7	111,726	75.9
80 - 89%	15	510,690	84.3
90 - 99%	13	754,340	95.2
100% or more	12	$ 441,326	109.8
Sub-total	51	$1,887,513	93.4

APPENDIX IV APPENDIX IV

DISTRIBUTION OF 1988 MEDIGAP LOSS RATIOS
FOR POLICIES THAT HAVE BEEN IN FORCE FOR 3 YEARS OR MORE

For policies sold to groups,
with more than $250,000 in earned premiums

Commercial plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 45%	4	$ 6,725	38.0
45 - 54%	3	1,317	48.4
55 - 64%	5	5,773	58.5
65 - 74%	7	34,778	68.5
Sub-total	19	$48,593	62.6
75 - 84%	3	$ 25,769	78.2
85 - 94%	3	4,474	92.4
95 - 104%	1	568,199	102.4
105% or more	3	1,493	161.3
Sub-total	10	$599,935	101.5

Blue Cross/Blue Shield plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 45%			
45 - 54%	2	$ 2,496	47.8
55 - 64%	2	1,534	58.1
65 - 74%	4	43,598	73.3
Sub-total	8	$47,628	71.5
75 - 84%	5	$ 30,939	79.3
85 - 94%	11	134,125	91.3
95 - 104%	4	173,024	96.3
105% or more	6	22,688	112.8
Sub-total	26	$360,776	91.4

DISTRIBUTION OF 1988 MEDIGAP LOSS RATIOS
FOR POLICIES THAT HAVE BEEN IN FORCE FOR LESS THAN 3 YEARS

For policies sold to individuals,
with more than $250,000 in earned premiums

Commercial plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 40%	17	$ 50,387	32.6
40 - 49%	23	88,986	44.1
50 - 59%	43	476,239	54.8
Sub-total	83	$615,612	51.4
60 - 69%	33	$447,597	62.4
70 - 79%	12	160,302	71.4
80 - 89%	5	13,573	85.9
90 - 99%	3	20,082	93.4
100% or more	2	8,000	114.7
Sub-total	55	$649,554	66.7

Blue Cross/Blue Shield plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 40%			
40 - 49%			
50 - 59%			
Sub-total			
60 - 69%	7	$ 89,699	68.5
70 - 79%	6	127,254	73.9
80 - 89%	10	479,385	85.6
90 - 99%	10	452,326	94.0
100% or more	3	$ 66,606	108.1
Sub-total	36	$1,215,270	87.5

APPENDIX VI APPENDIX VI

DISTRIBUTION OF 1988 MEDIGAP LOSS RATIOS
FOR POLICIES THAT HAVE BEEN IN FORCE FOR LESS THAN 3 YEARS

For policies sold to groups,
with more than $250,000 in earned premiums

Commercial plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 45%	1	$ 3,246	34.0
45 - 54%	4	21,213	48.0
55 - 64%	4	11,309	59.3
65 - 74%	6	11,956	72.2
Sub-total	15	$47,724	55.8
75 - 84%	1	$ 521	77.7
85 - 94%	1	60,265	92.8
95 - 104%	3	553,092	100.6
105% or more	1	1,828	117.6
Sub-total	6	$615,706	99.9

Blue Cross/Blue Shield plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 45%	1	$ 561	42.8
45 - 54%			
55 - 64%			
65 - 74%	2	12,406	68.4
Sub-total	3	$12,967	67.3
75 - 84%	6	$ 87,947	81.9
85 - 94%	5	217,078	93.0
95 - 104%	1	24,136	95.9
105% or more	4	34,394	115.2
Sub-total	16	$363,555	92.6

Chairman STARK. Thank you very much.

You've made recommendations relative to the current Baucus amendments. However, you also indicate that under the current regulatory structure, many States allow substandard policies to be sold. I would presume then that if we just raise the loss ratio targets and didn't change the method of regulation, we might not see all the loss ratios.

In your opinion, what happens? Some States just ignore it, some States don't prosecute for companies who don't—why aren't the so-called standards working now?

Ms. SHIKLES. Well, a large number of States are not enforcing the minimum standards you have in place now. So stronger enforcement action on the part of States is clearly needed because we have had policies year after year fall way below even the minimum standards.

Chairman STARK. OK. What do the States that do enforce the standards do? Can you give me an example of something a State does? Do they put the person to death, give them a 20-year jail sentence, fine them $10? I mean what is the practice across the land?

Ms. SHIKLES. Well, in our work that we have been doing for this subcommittee, we visited several States, and we are still analyzing that data. We found that a few States have started to look at the loss ratio data and deny premium increases, which is what they are supposed to do. And some have been taking other types of actions. But we are just seeing a small number doing that.

Chairman STARK. So one company has a 34-percent loss ratio. Maybe in 10 years, if you kept denying them premium increases, they might get up to 60 percent, would that be——

Ms. SHIKLES. That's right.

Chairman STARK. Is that the only mechanism available to the States insofar as the State law is concerned? Does the State law allow them to restrict policies sold to penalize the companies in some way?

Ms. SHIKLES. Yes, they could restrict the policies being sold if they continue to not meet standards—and certainly you'd start by denying any increase or have a rebate to the policyholder.

Mr. DOWDAL. There is a lot of variation in the authority that States have to regulate the premiums, and that kind of stuff.

Chairman STARK. What is the toughest State that you know of? I mean where do they really hammer on this if they step out of bounds?

Mr. DOWDAL. Well, I wouldn't want to categorize any State as saying it hammers them. But, well, in the past, Pennsylvania has been relatively aggressive. And, you know, there's a number of States that have done more than other States.

Chairman STARK. From an economic standpoint, is there any justification for a company after 3 years where I understand there's some problem in getting started? After 3 years, is there any real case that can be made for a loss ratio that doesn't meet the present NAIC standards

Ms. SHIKLES. No, there's no case that could be made. And as we indicated, we think the standards are low.

Chairman STARK. In these minimum loss ratios, is it difficult to determine whether policies comply or not. Is it a humongous task

to take all of these companies and figure out whether they are meeting the target or not? Do you need the Defense Department computer system to track all that?

Ms. SHIKLES. No. There has been a change in the way they report the data and that shows up now in the 1988 data, and it is pretty straightforward. See, a State could very readily interpret whether the policies were meeting the loss ratios or not. You wouldn't need a sophisticated staff to do it.

Chairman STARK. How many companies in the country roughly sell this?

Ms. SHIKLES. About a couple hundred.

Chairman STARK. A couple hundred. How long would it take you each year with a big MacIntosh computer to check these couple of hundred companies, and identify for me which ones meet the loss ratio and which ones don't?

Would it take 10 employees 10 months, 100 employees 1 month? What do you get?

Ms. SHIKLES. Well, we did that and it took a couple of days? I don't know.

Mr. DOWDAL. If the only thing you wanted to know is whether or not they met the loss ratio, that would be relatively simple, and we could do that pretty easily with one person and a computer.

Ms. SHIKLES. That's correct.

Mr. DOWDAL. If you want to then translate that into how much is the next year's premium is going to go up, that's a different story because then you have to look at the actuarial justifications that the insurers are giving.

Chairman STARK. But just to enforce the minimum standards.

Ms. SHIKLES. That's very straightforward.

Chairman STARK. This would not take much of a bureaucracy, is that your opinion?

Ms. SHIKLES. No. One of our staff could do that very quickly.

Chairman STARK. So that would not be a very difficult thing to administer?

Ms. SHIKLES. No, it would not.

Chairman STARK. OK. You also recommend that we get into the 80 and 85 percent range on minimum loss ratios. What is your estimate of the premium dollars, not necessarily company, but the total money paid that wouldn't meet that 80 to 85 percent range?

Ms. SHIKLES. Well, currently, about a third of the individual premium dollars and about 14 percent of the group policies wouldn't meet those new standards.

So the majority of the earned premium dollars now are meeting higher standards.

Chairman STARK. Thank you very much.

Mrs. Johnson.

Mrs. JOHNSON. No questions, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Are the loss ratios very different than you would find in other areas of insurance? Are we seeing a very different dynamic here than we are in other areas?

Ms. SHIKLES. We were going to try to get data on that. Were we able?

Mr. DOWDAL. It is hard to categorize the different kinds of insurance and compare them directly because of the different ways they have loss ratios. I mean the computed reserves for future claims and things like that.

If you look at industry averages overall for things like fire insurance and automobile casualty insurance and malpractice insurance and that kind of thing, they are generally around the 80 percent, between 70 and 80 percent range on the average.

Mr. LEVIN. How about other health insurance coverage?

Mr. DOWDAL. Accident and health insurance is the category that they lump all of that health insurance into. And I believe that for 1988 the loss ratio was in the low 80 percents, the industry wide average.

Mr. LEVIN. If that's true, is your conclusion that there is a special problem here?

Mr. DOWDAL. There's a lot of difference between a medigap policy and a comprehensive medical policy, in the amount of risk that you take and the difficulty in figuring out what the premium ought to be, and all kinds of other factors.

In a medigap policy, you are primarily covering only Medicare's coinsurance and deductible amounts. And that makes that a lot easier to figure out how much you are going to pay out during the year versus a comprehensive medical policy where you're covering whatever happens under all those different kinds of benefits you have in it. So it is a little hard to compare medigap with general health insurance because of the differences in the kind of product.

Mr. LEVIN. Since the risk is lower, you would expect that the loss ratio would be worse?

Mr. DOWDAL. I wouldn't expect that.

Mr. LEVIN. So basically you have the reverse of what you would expect.

Mr. DOWDAL. Yes. One would think that medigap would be a little easier to figure out, and there would be less risk for an insurer and, therefore, they would need less play room in their premium.

Mr. LEVIN. Yes. Do you understand why that apparent dynamic is within the medigap industry arena?

Mr. DOWDAL. I don't know why there are companies that have those low loss ratios. Maybe the insurance commissioners can tell you—they are going to testify later and may be able to give you a better answer.

Mr. LEVIN. When you break out the loss ratio figures, do you see a particularly high amount of dollars for sales? I mean is that one possibility that the overhead, et cetera, is higher?

Mr. DOWDAL. From the information we've got gathered over the years, there are a number of companies that do pay very substantial portions of the premiums as commissions to the salesmen. So, a significant portion of the overall premium dollars was going for marketing expenses.

Mr. LEVIN. And that may be higher in this area than in some others?

Mr. DOWDAL. I'm not really that familiar with other kinds of insurance so I couldn't say.

Mr. LEVIN. We were reviewing in the office some of the material from Michigan, and the brochure that's given out says Michigan law does not apply to policies which are legally issued in other States.

What does that mean? I mean I know what it means, but why is that there, do you think?

Mr. DOWDAL. There's a special class of policies that are sold to an organization or an entity, a master policy is sold. And they then will sell the members of the organization a certificate of insurance. And this doesn't have to be a formal organization like the Elks Club or something like that.

But then, in a number of States, the State where the master policy is sold is the one that does the regulating of the policies. And if a person who buys a certificate under that policy, for example, in Michigan, has trouble with the company or the policy, the Michigan insurance commissioner can't really do much about it because that policy is regulated by an insurance commissioner in another State.

Mr. LEVIN. Under the law, they can't? I mean there's settled law that—-

Mr. DOWDAL. It's dependent again somewhat on what the State law is. Different States have varying degrees of things they can do. But the primary responsibility is with the insurance commissioner where the master policy is sold.

A number of those kind of policies are sold in the District of Columbia.

Mr. LEVIN. Just one last question. In referring to State regulation, if there is a problem here of inadequate regulation, let's assume that for a moment, though not ultimately. The hearing will help tell that.

Why aren't the States more active?

Ms. SHIKLES. It's really just how aggressive the State insurance departments have been, how many staff they put on it, whether they wanted to follow up on the problem.

Mr. LEVIN. We've had had discussion in recent months and years about the States being the hothouses, the greenhouses and the like for programs, for new ideas, for experiments, what's the problem here? I mean if there is a problem of inadequate regulation, why aren't the States more vigorously involved?

Ms. SHIKLES. One thing that could be done to help is that some States are not prior approval States for premium rates. And if that was changed so that they had to approve the rate increases, that would begin to maybe get them more involved in reviewing the policies and then enforcing the standards. But, in many cases, it is not a question of inadequate regulations; it is more a question of enforcement.

Mr. DOWDAL. Another thing is that the insurance commissioners, generally speaking, don't have a lot of staff. And they tend to put the staff in the areas that are of most interest to the general population, like automobile liability insurance or something like that, or where there's a lot of complaints.

In the medigap area, there is normally not a lot of complaints to the States because the medigap insurers pay the claims when they get sent in.

If somebody thought they were getting ripped off when they bought three different policies that covered the same thing, they wouldn't have bought three policies. So they don't complain about it. They thought they did something that was OK.

So there isn't a lot of complaints that are related to the problems with the medigap policies.

Mr. LEVIN. Are there clear figures indicating how many people in the country have more than one policy?

Ms. SHIKLES. No. The surveys range from about 15 to 40 percent, I think. And different surveys come up with different figures. There's no data base that would track that.

Mr. LEVIN. Thank you.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman.

In your testimony, and as I followed what you said, you made some comments about the term "loss ratio," and the fact that recently that definition has changed, or at least the reporting requirements have changed which I assume would alter somewhat the information that we're getting.

In addition to that, it seems to me that we are, of course, interested in having people insured by companies which are healthy, which will be there at the time in the future when claims are made. So we want them to earn enough to stay in that healthy condition, and the loss ratio may not necessarily reflect that condition.

Also, the age of the policy, the age of the company, all of these things seem to have considerable relevance on whether the company is in fact healthy or not.

So, it brings to my mind the question of whether the loss ratio, is the best concept to use in gauging whether the consumer is getting his or her money's worth when purchasing medigap, or any other insurance for that matter?

Ms. SHIKLES. Well, it's the best one we have available to use to look at the value of the policy to the consumer. And in our analysis of this data, we followed the NAIC model guidelines where we are only analyzing policies that have been in force for 3 years or longer which allows for startup time and adjustment. And only policies when the current premiums are above $250,000 because people believe that below that level it would be too difficult to make that assessment.

The loss ratio is valuable because you can monitor it each year and, as we mentioned earlier, this is not a high risk policy area. As long as we have been monitoring this data for this subcommittee, the large majority of premium dollars have been for policies with loss ratios in the 80 to 85 percent range.

Mr. CHANDLER. Are they still profitable when there are loss ratios that high?

Ms. SHIKLES. Yes.

Mr. CHANDLER. How high can it go before they become unprofitable, or can you answer that?

Mr. DOWDAL. That depends a lot on what their marketing costs are, because that's one of the major costs.

Mr. CHANDLER. Well, you see, that's why I asked the question, should we be using the loss ratio concept as a gauge to determine whether the consumer is being given a good deal or not?

Ms. SHIKLES. Well, it's a gauge to tell you that this policy pays out about 80 percent of the earned premiums and benefits. And if they misjudge 1 year, then they would come back to the State and ask for a rate increase to make the adjustment the next year.

So we show in our data that some companies have loss ratios that are 100, 101 percent so they no doubt came in the following year and asked for a premium increase because it——

Mr. CHANDLER. Right. But a State insurance commissioner would more likely use the profitability of the company as the gauge of whether to allow a premium increase rather than the loss ratio. And then it might be a factor, but it certainly wouldn't be the only one.

Ms. SHIKLES. Well, they are supposed to make sure that they meet the minimum standards.

Mr. CHANDLER. No, I understand that.

Ms. SHIKLES. Yes.

Mr. CHANDLER. Yes. But I mean it's one factor, not the only one.

The other question—when you found companies that had a very low loss ratio, and I think you mentioned one that was down in the 30 percent range, did they follow with premium reductions, or were you able to tell that consumers reacted in any particular way? Obviously, for that low a loss ratio, the relative premium rate is going to be high. In other words, you are not getting as much for your money as you would like.

Did consumers shift? Did they respond by buying from someone else? Were you able to tell anything like that?

Ms. SHIKLES. Well, we just got this data, and we just put this analysis together for the hearing. So we haven't tracked it back to see what happened.

Mr. CHANDLER. Sure. Because in an ideal world it would be better just to allow the marketplace to work, and I'm trying to get at whether, if that in fact works or not——

Mr. DOWDAL. There are policies that have been in the low loss ratio range for years and years and years. And they are still being sold.

So I don't know how well the market is working or isn't working on those. But there are companies that have been down in the 40-percentile and 50-percentile range, far below other companies for years since we've been looking at it.

Mr. CHANDLER. And their premiums never went down or continued to go up?

Mr. DOWDAL. The loss ratios have not come up.

So it indicates that——

Ms. SHIKLES. The premiums didn't go down.

Mr. CHANDLER. All right. Thank you. Mr. Chairman.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

I notice that in your statement you spent a good deal of time talking about the fact that medigap insurance premiums are anticipated to go up, and about half of this increase is attributable to the repeal of catastrophic health insurance.

We didn't see a dramatic reduction in the medigap insurance premiums as a result of catastrophic.

Can you give us any insight as to why there would be such a large increase in premiums attributable to the repeal of the Catastrophic Act?

Ms. SHIKLES. Well, I think, as we testified before this subcommittee last year, premiums didn't drop that much, or some didn't drop at all, because the part of catastrophic that went into effect last year didn't cover that much. And the real change you would have expected to see this year when the really extensive coverage was to go into effect. And you would have expected to see very low premium rate increase requests.

We don't have a legal access to these data so we can only report what the insurers, the companies tell us. And they're saying that about half the increase is due to the repeal of catastrophic. They had to factor back in the part A coverage that was covered under catastrophic. And the other increases would be due to prior claims experience.

Mr. CARDIN. What you're saying is the overall increase is 19.5, and they are saying about half of that, or about 10 percent is attributable to the Catastrophic Act Repeal. And yet the benefits in the first year were rather minimal.

I don't see how there could be such a large increase attributable just to the repeal of catastrophic.

Ms. SHIKLES. We can only tell you what they report to us because we can't look at their justification because we don't have that kind of access.

Mr. CARDIN. You also point out the administrative cost necessitated by the repeal of catastrophic.

Could you elaborate more as to why they believe there is an increase in premiums relative to an administrative cost?

Ms. SHIKLES. Well, they just told us that they had to make changes in policies and send out notices to policyholders having to do with the repeal of catastrophic and the new policies this year. And I think administrative cost issues would be low, but that was just one of the reasons that they gave to us.

Mr. CARDIN. Of course, that would be a one time only expense.

Ms. SHIKLES. That's correct.

Mr. CARDIN. So you would expect that that would then come out of their premium base in the following year.

Ms. SHIKLES. That's correct.

Mr. CARDIN. Thank you, Mr. Chairman.

Chairman STARK. If I could just follow up on one item which may come up later, and which my distinguished colleague from Washington alluded to, and that is the recommendation or the suggestion that the possibility of judging future premiums might deal with profitability.

Are either of you familiar with how insurance commissioners calculate profitability for insurance companies?

Ms. SHIKLES. I'm not certain. I think each State does it somewhat differently, and asks for different sets of data from the companies.

Chairman STARK. Let me rephrase that.

Is there a vast difference between the way an insurance commissioner is apt to calculate profitability and the SEC, for instance, or the CPAs in what is normally referred to as book income? Are you familiar with that? Are either of you?

Mr. DOWDAL. I'm not really familiar with how the States go about it.

Chairman STARK. We'll ask somebody else.

One other question to ask. Under the indemnity policies some years ago, you did a study on loss ratios did you not?

Ms. SHIKLES. That's correct.

Chairman STARK. I'm not sure, but it looks to me like the average you calculated was 55 percent.

Now, a good number of companies were substantially below this figure. One, Pennsylvania Life sold $61 million in premiums, and had slightly less than a 6 percent loss ratio which, by my calculations, means they slammer about $58 million away in their pocket. Not a bad return. But they were the lowest. I can't tell where the median is in here as opposed to the average.

Have either of you ever played roulette?

Ms. SHIKLES. Yes.

Chairman STARK. What do you think the odds are in just playing the red all the time? Do you know? What are they?

Ms. SHIKLES. I don't know.

Mr. DOWDAL. Fifty-fifty.

Chairman STARK. No. The double zero knocks it down, so maybe 48 percent.

Starting with Mutual of Omaha at 42 percent on just about $100 million worth of premiums, why not have some fun?

Do you know if there are generally maximum benefits in these indemnity policies? It's usually, in round figures, $30 a day, $50 a day for 30 days. So you're really talking about $900, $1,500.

Is it generally the practice in the industry to have a cap on what they will pay out on these policies?

Mr. DOWDAL. Well, I think generally, most of them, if I recall, they cover a full year. But the average length of stay for a person is 5 or 6 days. So, you know, on the average, you're not going to get anywhere near a year's benefit.

As we pointed out in that report, if you were paying about $400 a year for the policy, which I believe at that time was somewhere around the average, your expected benefit was $50.

Chairman STARK. So, for the $400, you get four $50 chips, and you ought to be home free, huh?

I thank the witnesses very much.

Chairman STARK. Our next panel consists of three witnesses. We are pleased to welcome among them Gail Shearer, who has been before the committee before. She is the Manager of Policy Analysis for Consumer's Union. She appeared before the subcommittee last year at a hearing on standards for private long-term care insurance.

I also would like to welcome Betty Jane Long, a member of the American Association of Retired Persons, National Legislative Council; and Bonnie Burns, a consultant from the Health Insurance Counseling and Advocacy Program of Scotts Valley, Calif.

I want to suggest that while I think Consumer's Union is a wonderful organization, that we all have to take the bitter with the sweet.

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I have had on my desk for a long time your article on Medicare and which are the best policies and so forth. But I really have a complaint, and I must take this opportunity.

I also read your article in there on facial cleanser. I had a big spot on my nose when I was on television Sunday, and I found out that you said I should close my eyes when I put it on, and I got it all over my tie.

So I just want to warn you that consumers' reports are not always 100-percent correct.

Ms. SHEARER. Well, I'll pass that along.

Chairman STARK. Thank you. Proceed.

STATEMENT OF GAIL SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION

Ms. SHEARER. Mr. Chairman and members of the subcommittee, Consumers Union appreciates the opportunity to present our views on the issue of private health insurance to supplement Medicare or medigap insurance.

We commend Chairman Stark for introducing legislation that would reform the regulation of the medigap market, and for holding this hearing.

The Federal Government has a special obligation to monitor the performance of this market since the design of its own Medicare program has in effect created the supplemental market, and because there's a great deal of confusion about where Medicare ends and private responsibility for health care cost begins.

Medigap premiums seem to increase regardless of whether Medicare benefits grow or shrink. And this troubles consumers. We urge the Congress to use the window of opportunity it now has with the growth of the medigap market after the repeal of the catastrophic bill to both critically review and improve the medigap market. True reform of this market would be an appropriate way to celebrate the 25th anniversary of the enactment of the Medicare program.

In my testimony, I plan to describe the key abuses in the medigap market, comment on the legislation introduced by Chairman Stark, and propose several additional legislative steps that this subcommittee should consider.

Perhaps the biggest problem in this market is the consumer confusion that results from the array of choices in the marketplace. Marketers of insurance have taken the normally sound principle of consumer sovereignty or consumer choice past any reasonable limit. The variation in policies, the choices we force senior citizens to make are much more complex than any they had to make when they were younger.

As employees, most of us are able to rely on our employers to shop for health insurance and to offer broad choices in coverage.

In a previous job as a Federal employee, I was able to choose from an array of insurance packages. Blue Cross and Blue Shield, for example, offered a standard or a high option. If this type of system works so well for people under 65, why can't we simplify the medigap market and offer senior citizens a meaningful choice in this extremely complicated market?

If confusion is the number one consumer problem, then duplicate coverage and overselling comes in a close second. AARP recently found that 24 percent of people owning health insurance in addition to Medicare owned two or more policies, and 5 percent owned three or more.

Based on the AARP survey, we estimate that 1.5 million senior citizens are wasting a total of about $1 billion a year on excessive medigap policies along, without even counting the money spent on low-value hospital indemnity and dread disease policies.

As the GAO has documented, loss ratios of far too many companies continue to be below the standard required by State regulators. Abusive agent practices are another severe problem in this market.

The Senate Select Committee on Aging heard testimony last week about how some companies train their agents to victimize the elderly by twisting them from one policy to another, by selling them too many policies, by playing on their fear of health expenses.

Another problem with this market is the practice of lead card companies that send out mailings to senior citizens requesting that the recipient fill in and return the card enclosed in the mailing. In many cases, the mailings use names to make recipients think that the sender is an official Government agency. Some of the names include National Health Information Center, Consumer Referral Center, and Medicare Division. The lead card company then sells the names of senior citizens who requested information to insurance companies who then send an agent to the consumer to make the sale.

The key ingredients to effective reform of the medigap market are, first, the correct regulatory framework. Second, highly motivated regulators armed with sufficient resources for the task; and, third, a fully informed consumer.

Chairman Stark's Federal Medicare Supplement Insurance Improvement Act of 1990, would take steps to substantially improve the regulatory framework, and adds the power of the Federal Government in enforcing the higher regulatory standards.

We strongly support this legislation and offer the following comments:

In the interest of time, I will mention some of the features in the bill that we strongly support.

First, we support the Federal role Chairman Stark outlines to complement the State regulation of insurance, with the Federal Government enforcing higher loss ratio standards and enforcing uniform standards for medigap policies.

Second, the Stark proposal would facilitate comparison shopping by requiring companies to market a standard minimum benefits policy and offer a limited number of standard optional riders.

Third, the provision prohibiting the sale of duplicative health insurance to the elderly could save senior citizens several billions of dollars per year.

Fourth, the bill would restrict the sale of hospital indemnity and dread disease policies which tend to be extremely poor buys.

Fifth, by banning medical underwriting, the proposal would level the playing field between companies that presently underwrite

risks and those that do not. It will help ensure access to health insurance for all senior citizens.

And, sixth, the proposal would improve the value of many policies by increasing the minimum loss ratio and providing the Federal Government with the role in enforcing these.

There are two proposals we would like to offer to make Chairman Stark's bill even more effective.

First, Congress should establish a grant program to encourage States to establish comprehensive counseling programs for health insurance for the elderly. Twelve States have such programs, and they have proved to be both very effective and very popular.

Second, the Congress should build on Chairman Stark's proposal by grouping options to help senior citizens truly compare apples with apples. This is along the lines of I think Congresswoman Johnson——

Chairman STARK. I just want to say as long as you're praising this bill, don't pay any attention to that light. I mean you're going in the right direction.

Ms. SHEARER. Massachusetts and Minnesota already do this. In Massachusetts, all medigap policies are required to comply with one of the four benefit options and cannot be modified.

In Minnesota, there's a basic policy with four optional riders. In addition, insurance can offer extended basic coverage which must provide all the coverage offered in the basic policy and optional riders, and a few additional provisions such as the catastrophic benefit.

In conclusion, marketing abuses in the Medicare supplement insurance industry continue to victimize the country's senior citizens. Congress should enact legislation that would put an end to these abuses and make it possible for consumers to spend their health insurance dollars effectively.

We commend Chairman Stark for his far-sighted proposal.

[The statement of Ms. Shearer follows:]

STATEMENT OF GAIL SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION

Mr. Chairman and members of the Subcommittee, Consumers Union[1] appreciates the opportunity to present our views on the issue of private health insurance to supplement Medicare ("Medigap" insurance). We commend Chairman Stark for introducing legislation that would reform the regulation of the medigap market, and for holding this hearing. The federal government has a special obligation to monitor the performance of this market, since the design of its own Medicare program has in effect created the supplemental market, and because there is a great deal of confusion about where Medicare ends and private responsibility for health care costs begins. Medigap premiums seem to increase regardless of whether Medicare benefits grow or shrink, and this troubles consumers. We urge the Congress to use the window of opportunity it now has -- with the growth of the medigap market after the repeal of the Catastrophic Bill -- to both critically review and improve the performance of the medigap market. True reform of this market would be an appropriate way to celebrate the 25th anniversary of the enactment of the Medicare program.

In my testimony, I plan to describe the key abuses in the medigap market, comment on the legislation introduced by Chairman Stark, and propose several additional legislative steps that this Subcommittee should consider.

MARKETING ABUSES AND MARKET FAILURE

Following the enactment of the Baucus amendment in 1980, there was relatively little publicity about abuses in the medigap market. But, unfortunately, this was not because the Baucus amendment had dramatically improved the performance of the market. The June 1989 issue of Consumer Reports provides some disturbing information about marketing abuses. The article uncovered examples of agent ignorance, high-pressure marketing techniques, agent efforts to sell unnecessary policies, frivolous variation between policies, and a marketplace characterized by confusion rather than clarity. The article concludes that the Baucus amendment has ot cleaned up the Medicare supplement industry. "Sales abuses still abound, misrepresentation continues unabated, and there's evidence that some policies haven't achieved the target minimum loss ratios the [amendment] requires." Some of the key areas of market failure are described below:

1. Consumer Confusion and Lack of Knowledge: The proliferation of policies makes it virtually impossible for consumers to make an informed purchase decision. Research conducted after the enactment of the Baucus amendment shows that beneficiary knowledge of Medicare and medigap coverage is low. If consumers are misinformed about Medicare coverage, they are likely to be susceptible to sales pitches leading to more supplemental coverage than they need.[2] The June 1989 Consumer Reports article shows the extent of variation from policy to policy. Policies

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[1]Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide information, education and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of Consumer Reports, its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Report, with approximately 4.5 million paid circulation, regularly carries articles on health, product safety, marketplace economics, and legislative, judicial, and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

[2]Nelda McCall, Thomas Rice, and Judith Sangl, "Consumer Knowledge of Medicare and Supplemental Health Insurance Benefits," Health Services Research 20:6 (February 1986, Part I), pp. 642, 649.

vary, for example, with regard to whether (or to what extent) they cover: private hospital rooms, in-hospital private nurses, skilled nursing home stays beyond 150 days, the Part B deductible, excess physician charges, foreign travel, and pre-existing conditions.

2. Duplicate Coverage/Overselling. Some people buy more than one medigap policy, paying thousands of dollars in premiums to buy overlapping, duplicative coverage. Since companies do not tend to coordinate benefits, these consumers are able to collect benefits from all of the policies they own. The problem here is that uninformed consumers, who are extremely afraid of health care costs, waste their limited dollars by over-insuring. Attached to my testimony are some troubling examples of consumers who were persuaded to buy multiple policies. Equally disturbing, though, is the large percent of senior citizens who own two or more policies. A recent survey by AARP found that 24 percent of people owning health insurance in addition to Medicare owned two or more policies, and 5 percent owned three or more.[3] While most of this duplication results from the ownership of a medigap policy and one or more hospital indemnity insurance policies, seven percent of the people surveyed who own private insurance owned two or more Medicare supplement insurance policies. This means that more than one and a half million senior citizens are wasting (in aggregate) roughly a billion dollars a year on excessive medigap policies alone (without even counting the money spent on low-value hospital indemnity and dread disease policies). The regulatory system should provide a market structure that allows consumers to spend their limited dollars on just one policy to meet their needs.

3. Low-Value. The General Accounting Office's 1986 results about loss ratios were disturbing. While the Baucus amendment established a target loss ratio of 60 percent for individual policies, the GAO found that 254 of the 398 policies (64 percent) it reviewed had loss ratios below the target, in its study of 1984 loss ratios. The average loss ratio for commercial medigap policies was only 60 percent.[4] The GAO recently testified that while Blue Cross and Blue Shield plans in general met target loss ratios in 1988, many commercial insurance companies continue to perform below the target loss ratio, even though most states now have regulations and/or laws that require enforcement of actual loss ratios (not merely "target" loss ratios). The GAO found that 34 percent of the company loss ratios were below the 60 percent minimum standard for individual policies, and 66 percent of the commercial company loss ratios were below the 75 percent minimum standard for group coverage.[5]

4. Twisting. Twisting is the term used to describe a common agent practice of convincing a client to switch policies. Agents have an incentive to do this since many policies have front-loaded commissions. In other words, the agent earns a hefty commission for first-year premiums, and much less for policy renewals. Consumers often do not benefit from being "twisted" to a different comparable policy, and face increased costs of uncovered charges, since they may face new exclusions for pre-existing conditions.

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[3]Consumer Awareness of Medigap Insurance: Findings of a National Survey of Older Americans, AARP, 1989, pp. 10, 14.

[4]Medigap Insurance, Report to the Subcommittee on Health, Committee on Ways and Means, House of Representatives, October 1986.

[5]Statement of Janet Shikles, Director, Health Financing and Policy Issues, Human Resources Division, before the Subcommittee on Medicare and Long-Term CAre, Committee on Finance, United States Senate, on "Medigap Insurance; Expected 1990 Premiums After Repeal of the Medicare Catastrophic Coverage Act and 1988 Loss Ratio Data," February 2, 1990, p. 7.

5. Deceptive Lead Card Company Practices. As described in Consumer Reports, lead card companies send out mailings to senior citizens, requesting that the recipient fill in and return the card enclosed in the mailing. In many cases, the mailings use names to make recipients think that the sender is an official government agency. Some of the names include: National Health Information Center; Consumer Referral Service Center, Medicare Division; and Senior Citizens Health Services. Some companies use mailing addresses that are post office boxes in Washington, D.C., to give the impression of a government connection.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONER'S REVISED MODEL REGULATION

In December, 1989, the National Association of Insurance Commissioners (NAIC) revised its model regulation of medigap. The NAIC should be commended for taking several positive steps, including:

-- prohibiting pre-existing conditions on replacement business;
-- prohibiting the sale of a policy if the purchaser's total coverage would exceed 100 percent of actual medical expenses;
-- restricting the front-loading of agent commissions; and
-- encouraging state counseling efforts.

The NAIC actions, however, will not solve all medigap problems. There are uncertainties about whether states will enact the changes, and there are substantial uncertainties about whether the regulation as written is enforceable and whether states will devote sufficient resources to enforce them. In addition, we regret that the NAIC chose not to take steps to standardize the medigap market. We continue to believe that consumers desire a meaningful range of choice in this market. Chairman Stark's proposal addresses these concerns by requiring policies to comply with the NAIC standard.

COMMENTS ON THE FEDERAL MEDICARE SUPPLEMENT INSURANCE IMPROVEMENT ACT OF 1990

The key ingredients to effective reform of the medigap market are: (1) the correct regulatory framework; (2) highly motivated regulators, armed with sufficient resources for the task; and (3) a fully informed consumer. Chairman Stark's Federal Medicare Supplement Insurance Improvement Act of 1990 would take steps to substantially improve the regulatory framework and adds the power of the federal government in enforcing the higher regulatory standards. We strongly support the legislation, and offer the following comments.

Federal vs. state enforcement. While state efforts to improve the medigap market have been stepped up recently, and we respect the recent improvements the NAIC adopted to its model regulation, we question whether the states alone can bring the medigap market under control. State insurance departments have a long history of having insufficient resources to do their job effectively. Many departments don't even have an actuary on staff. We expect the state insurance departments and the insurance industry to argue that Congress should give the improved NAIC regulation a chance to be enacted and implemented. But we wonder how long consumers must wait for effective regulation of this market. The industry and the states made this same argument during the debate on the Baucus amendment ten years ago. We support the complementary federal role Chairman Stark outlines in his proposed bill, with the federal government playing a role in enforcing higher loss ratio standards and in enforcing uniform standards for medigap policies. At the same time, we urge you to provide the DHHS with adequate resources to enforce the new law effectively, and to closely monitor its enforcement efforts. We also recommend a role for the Federal

Trade Commission, which monitors marketing practices in virtually every other industry in this country.

Facilitating Comparison Shopping. The proposed bill would require that companies market a standard minimum benefits policy, and could offer a limited number of standard optional riders, to cover benefits such as the Part A hospital deductible, prescription drugs (at three benefit levels), foreign travel, and charges above the Medicare charges. This would greatly facilitate comparison shopping. Consumers could compare the premium for the basic policy and riders they select for policies from a number of different insurance companies. Since the definition of key coverage would be standard (e.g., how policies define the amount of balance billing charges that would be covered), meaningful premium comparisons would be possible. We believe that grouping of options (as described below under section 2 on standardization), as presently done in Massachusetts and Minnesota, would further help consumers compare the prices of similar products.

Anti-duplication. Chairman Stark's proposal would have the effect of prohibiting the sale of duplicative health insurance policies to the elderly. We strongly support this effort, which would save senior citizens (in aggregate) several billions of dollars per year, when duplicative sales of hospital indemnity, dread disease and medigap policies are taken into account. We also support the banning of sales of policies to people eligible for Medicaid. The proposed national register of ownership of policies will help identify duplicative sales and should help both the federal government and the states to enforce the law.

Employer-sponsored Policies. It is entirely appropriate for employer-sponsored plans to be covered by this legislation. Efforts to simplify this market would be undercut if employers could continue to provide (either with or without subsidies) plans that are "non-conforming." Without this provision, coverage would in effect force the employees to seek coverage that would be (at least partially) duplicative.

Hospital Indemnity and Dread Disease. Hospital indemnity and dread disease policies are designed and marketed to play on senior citizens' extreme fear of health care costs. The tend to be very poor buys. (The FTC staff found that "neither of these policies should be considered to be a good alternative for persons seeking broad coverage of costs for health care that Medicare does not pay." The GAO reported that these policies are of limited value.)[6] We would like to see the sale of new hospital indemnity and dread disease policies to the elderly banned outright. The bill would basically ban the sale of such policies to people already owning a Medicare supplement insurance policy (since it would be considered duplicative). It is possible that such a policy could, however, be sold to someone without a medigap policy. Such a consumer could be in the position of being without one comprehensive medigap policy. The proposal would help, but we believe an outright ban would be even better.

Underwriting. By banning medical underwriting, Chairman Stark's proposal would level the playing field between companies that presently underwrite these risks and those that do not. This provision will help ensure access to health insurance to all senior citizens. To complement this provision, we recommend that you instruct the DHHS to monitor access the health insurance, in particular to make sure that access is not limited by

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[6] Marketing of Medigap, Specified Disease and Hospital Indemnity Insurance to the Elderly: Report to the Committee on Energy and Commerce, U.S. House of Representatives by the Federal Trade Commission, Bureau of Consumer Protection, September 1988, p. 128; Health Insurance: Hospital and Specified Disease Policies are of Limited Value, General Accounting Office, July 1988.

inappropriately high differential premiums for high risks; these would limit access just as severely as medical underwriting would.

Loss Ratios. We support the increase in the minimum loss ratios that would be required for both individual and group insurance policies, and welcome the proposed federal role to enforce these higher loss ratios.

Counseling. Improved enforcement and an improved regulatory framework should go hand-in-hand with educational efforts to better inform consumers about the choices that they face in this market. We suggest that you add a counseling program, such as that recently introduced in the Senate by Senator Pryor, to the bill.

RECOMMENDATIONS FOR FURTHER CONGRESSIONAL ACTION

Chairman Stark's proposal includes a number of provisions that would significantly improve the Medicare supplement insurance market. I would like to expand briefly on some additional recommendations that would further improve market performance.

1. Congress should establish a grant program to encourage states to establish comprehensive counseling programs for health insurance for the elderly. Twelve states have counseling programs that train volunteers to sit down with the elderly on a one-on-one basis to counsel them about Medicare, private Medicare supplement insurance and long-term care insurance. The Health Insurance Counseling and Advocacy Program (HICAP) in California and Senior Health Insurance Benefits Advisers (SHIBA) in some other states have been extremely effective in eliminating duplicative coverage and advising senior citizens of their coverage and their choices. The HICAP program, for example, estimates that by eliminating inappropriate coverage, senior citizens have saved twice as much money as the program costs. Congress should encourage all the states to establish their own counseling programs, by establishing a grant program and an information clearinghouse. Counseling is a non-controversial step that the National Association of Insurance Commissioners and industry representatives have endorsed.

2. Congress should STANDARDIZE the Medicare supplement insurance market. Chairman Stark's proposal would greatly facilitate comparison shopping by creating one standard basic benefits package and a limited number of optional riders. Even with a limited number of riders, however, the number of policy types on the market (basic policy with any combination of riders) could easily exceed 100. Two states have grouped the options to further simplify comparison shopping. In Massachusetts, for example, there are four levels of medigap coverage. All medigap policies sold in Massachusetts are required to comply with one of the four benefit options and cannot be modified.

In Minnesota, there is a **basic policy**, with four optional riders (Part A inpatient deductible, Part B annual deductible, balance billing charges, and prescription drugs). In addition, insurers can offer **extended basic coverage** which must provide all of the coverage offered in the basic policy and optional riders, and includes a few additional provisions such as a $1000 annual limit on money that the policyholder must pay out of pocket on covered medical expenses. The Minnesota plan preserves a good deal of flexibility for the consumer to select the options he or she wants, but also allows consumers who want a comprehensive policy to compare prices for one standard coverage package.

Chairman Stark's proposal could easily be modified to follow this model. A **basic** plan could include only the minimum benefits, and would have to be priced separately. As Chairman Stark proposed, a limited number of optional riders could be offered to supplement the basic plan. A **basic plus** plan could group some popular options, such as the Part A deductible and the Part B deductible. An **extended basic** plan could include all of the

optional riders (and possibly a catastrophic "cap" benefit, as in Minnesota). By grouping options, a consumer wanting the most comprehensive policy available could easily compare the price of identical coverage, without having to do any complicated calculations.

Support for standardization comes from people who are deeply involved in coming to the rescue of elderly people who have been victims of medigap abuses. At recent hearings of the Oversight Subcommittee of the House Energy and Commerce Committee, several witnesses called for standardization of the market. Don Gartner, an Assistant District Attorney for Santa Cruz County, California, whose office is litigating two civil lawsuits involving insurance and the elderly, said:

> Standardization of policies is important. California has about 200 Medicare Supplements approved for sale, with myriad ways of covering in dense language the same item. With such variation, there is little competition on price or quality of product. A consumer, old or young, cannot set two Medicare Supplement policies side-by-side and make an informed choice as to which is better or cheaper. Neither, for that matter, can a District Attorney or Department of Insurance regulator readily determine that a policy duplicates an earlier one in order to decide whether to prosecute for twisting.

Emory Walton, the Criminal District Attorney for Eastland County, Texas, with twenty years experience prosecuting fraud cases, also supported standardization:

> Uniformity of Health Care Policies: Today, there are almost as many types of health care insurance policies as Carter has liver pills . . . consequently the elderly are often misled or confused, and the easy victims of abuses in health insurance sales. In the casualty insurance field, there are generally accepted automobile and homeowners' policies which provide all of the coverages normally needed and allow the insured to choose the coverages and amounts deemed appropriate. A similar type of generally accepted health insurance policy could be developed for all types of health care insurance.

I would like to comment briefly on some of the concerns that members of the insurance industry have expressed about standardization:

Concern: Standardization would limit innovation. Some people have argued that standardization would limit innovation. For example, Blue Cross/Blue Shield testified that "Consumers have been well-served by worthwhile benefit innovations such as health promotion plans, dental coverage and eye care, and we believe that rigid control of the content of insurance policies would stifle, rather than enhance, market responses to changing consumer needs. . . . Moveover, standardization would impede the development of innovations that may contain Medigap costs, such as the use of preferred provider networks." [7] In most markets, we strongly endorse the principle of encouraging product innovation. We believe in this market, however, that medigap benefits should be structured to reflect the gaps in Medicare. Should Medicare benefits change, then standard benefits should be reviewed and changed if necessary, just as the National Association of Insurance

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[7]Testimony of the Blue Cross and Blue Shield Association on Issues Relating to Medigap Insurance Policies, Presented by Alan P. Spielman, Executive Director, Government Programs Legislation, before the Subcommittee on Medicare and Long Term Care, Committee on Finance, United States, Senate, February 2, 1990, p. 11.

Commissioners reviews its model regulation in response to Medicare changes. Many "innovative" changes in medigap benefits may be more beneficial to companies as a marketing tool to differentiate their product than to consumers as a true benefit.

Even with standardization, there can be room for innovation.[8] If insurers have a new idea for coverage they believe would be beneficial to consumers, they could petition the regulator (DHHS, in the case of Chairman Stark's bill) to make a new option available. The regulatory body should group such requests, and hold them up to a high standard that requires a very clear indication that any possible extra "confusion" in the marketplace is easily outweighed by the benefit of the new coverage. The regulator would also require that any new rider made available would be standardized (see example below). Criteria that the regulator could use in considering requests for new options would include:

-- Is the additional rider needed because of changes in Medicare benefits?

-- Does the proposal address a relatively "catastrophic" insurance need, or does it represent a first-dollar (dollar-trading) type of coverage. (The regulator should give more favorable consideration to catastrophic needs).

-- Can the regulator develop a "standard" for a rider of this type, to avoid proliferation of policy types? (Balance billing/excess doctor charge coverage, a relatively new type of medigap coverage, is a good example of where the market would have benefitted from government definitions of "standard" coverage, to avoid the vast array of definitions of this type of coverage.)

-- Will self-selection/adverse selection make such an option inappropriate/excessively expensive? Is the benefit likely to be needed by a relatively small portion of senior citizens? (For some types of proposed coverage, the regulator might want to consider revising the basic insurance policy standard).

-- Does the proposal advance a significant public policy objective (e.g., cost control)?

By way of example, balance billing coverage (protection against "excess charges" above the Medicare-allowed charge) is a relatively new type of protection offered by some medigap insurers. If it did not exist today, and insurers proposed it, the regulator could consider the request and could create an option for protection against balance billing charges. The regulator might come up with two standard options for a balance billing rider: the first (the low option) might define excess charge coverage to cover 50% of all physician charges above allowable charges. The second (the high option) might define excess charge coverage to cover 100% of all physician charges above allowable charges. Presently, insurers' coverage of charges above allowable charges is extremely confusing, since insurers have varying definitions of what constitutes an excess charge and because the percentage of excess charges paid varies, with amounts offered including 20%, 50%, 80%,

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[8]This proposal expands somewhat on Chairman Stark's provision to allow for innovation.

and 100% above allowable charges.[9]

Concern: Standardization limits consumer choice. We believe that senior citizens want a **meaningful** choice in the medigap marketplace, instead of the baffling array of choices that exists today. It does not make sense to force senior citizens to study the merits of 200 or 600 alternative policy types. In designing the standard policies (whether the regulatory framework be one standard basic benefit with optional riders or a low, medium, and high option), the Congress should take great care to include the benefits that senior citizens value. It would be appropriate and desirable for the standard policies on the market to have benefits very similar to those in policies now owned by consumers. The biggest problem with the market structure today is that there is not standardization of coverage, so consumers have a very difficult time comparing different policies. Senior citizens will welcome the simplification of this market, and will benefit tremendously[10] from standardization, assuming the design of the standard packages is done taking into account senior citizens' insurance goals.

Concern: Senior Citizens will find the transition to standardization confusing. With the experience with the Catastrophic Bill still so fresh, it is important to recognize the need to tackle the education needs of senior citizens early on in a transition to standardization. As the legislative process continues, attention should be paid to the appropriate transition requirements. Perhaps insurers should be required to offer consumers the standard policy that most closely matches the consumer's existing policy (and could offer other choices as well). Consumers who switch companies (or policies within the same company) should not be subject to new waiting periods for pre-existing conditions. Extensive educational efforts -- using for example cable TV programs, senior citizen meetings, brochures with questions and answers, new and ongoing counseling public and private counseling programs, senior citizen organizations and networks, should be extensive, to help ease the transition.

3. Congress should reform the commission structure for the sale of Medicare supplement insurance policies. High first-year commissions have been the driving force that has lead many agents to "churn" their policyholders from one policy to another. Minnesota recently established a level commission structure (level for the first four years, decreasing in later years). The NAIC recently changed its model regulation by limiting first year commissions to no more than 200 percent of second year commissions. If a policy is replaced, the new policy must be better than the old policy in order for the agent to earn the higher first year commission level. While we believe that this approach will probably help somewhat, we are concerned about the enforcement burden of this type of regulation. We believe that a level commission structure would be more effective and easier to enforce, and suggest that you consider modifying the NAIC model provision with respect to commission structure.

In conclusion, marketing abuses in the Medicare supplement insurance industry continue to victimize the country's senior citizens. Congress should enact legislation that would put an end to these abuses and make it possible for consumers to spend their health insurance dollars effectively. Consumers Union appreciates the opportunity to present our views.

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[9]The recently enacted limits in permissible balance billing provide important protection for consumers and may facilitate standardizing this type of coverage since the range of excess doctors' fees will be smaller.

[10]Consumers will benefit directly from the simplified market and indirectly through increased price competition.

ATTACHMENT: EXAMPLES OF VICTIMS OF OVERSELLING

Senior citizens all over the country are victimized by agents and companies who sell them multiple health insurance policies.

From Bonnie Burns, Medicare Specialist, California:

-- An 84-year-old woman (with no children) was sold 18 health insurance and life insurance policies by one agent, 2 policies by a second agent, though she already owned 2 group policies as a retired teacher. During an 18 month period, she paid just under $50,000 for 15 of these policies. (Ms. Burns filed a case on her behalf in August 1989.)

From Gerhardt Lehmkuhl, Attorney, Missouri:

-- A 70-year-old client was sold at least 27 health insurance policies.
-- Widow in her 90's was sold 12 Medicare supplement policies by 5 different agents from different agencies. (He recovered $5800 in premium for her).

From Don Gartner, Assistant District Attorney, Santa Cruz, California:

-- Widow, now 83, was sold 12 insurance policies in 1 year by an agent, and paid $6000 in premiums in 1985 alone. 5 of these policies were either Medicare supplement insurance or related to Medicare supplement insurance policies.
-- 79 year old woman was sold 24 policies, including 7 Medicare supplement policies, in less than 6 years.
-- 87-year-old woman was sold 19 policies in three and one half years, including 6 Medicare supplements.
-- An elderly couple (whose only income was $838 a month from Social Security) was sold 9 policies by one agent in 1985 alone.

From Emory Walton, Criminal District Attorney for Eastland County, Texas:

-- An elderly couple (in their 80's) was sold 13 health insurance policies (and 12 life insurance policies).

From George Davis, retired "Gapline" volunteer in Fort Worth, Texas:

-- An elderly couple living on social security income only was sold 6 supplemental policies, including 1 cancer policy and 1 hospital indemnity policy. One of the Medicare supplement policies was from the 1950's and paid only $10 a day for hospitalization. The couple was so broke from paying for their policies that they had to get assistance from the city to pay for their house.

Quoting from Senior Consumer Alert: A Special Bulletin for Complaint Handlers, Prepared by the National Consumer Law Center, Produced by the American Association of Retired Persons in cooperation with the National Association of Attorneys General:

-- In one seven-month period, Mrs. P., an 85-year-old widow, was sold eight health insurance policies by the same insurance agent. Some of these policies, with yearly premiums totaling $7529, contained overlapping coverage,. Others were of little or nor real benefit. Mrs. P. was unwilling to file a complaint against the agent because he know her address and she feared that he would return to confront her.
-- Mrs. R., an 89-year-old widow, was persuaded by her agent to spend much of her $12,000 savings account on 11 similar policies. He would visit her about three times a year to change or add to her coverage. When she complained that she could not afford the costly premiums, he told her shoe would be facing certain financial ruin unless she borrowed the money from friends or family. Mrs. R. never reported the agent because she was not award of any wrongdoing on his part.
-- Mr. H. wrote a check for $344 and gave it to his insurance agent a young man with a "very, very nice personality." He thought he was paying premiums on his medigap policy, but later discovered he had bought a new policy, which he did not want. He sent the policy back but could not get a refund or any response. He finally wrote the Florida Insurance Commissioner. "I am 90 years old and [it] seems as thought everyone wants to take advantage of me. Please help me if

your can."

Quoting from Harold Halfin, Volunteer, Dunn County Office of Aging, Wisconsin, testimony before Senator Herbert Kohl, December 7, 1989:

-- 92-year-old widow, whose income is just above the medical assistance level, thought she was buying insurance coverage for a nursing home. She currently has a comprehensive Medigap policy with an HMO. An insurance agent called on her and found she was concerned about nursing home coverage and proceeded to tell her he had the policy she needed. She paid him $861 for another policy that was nothing more than a Medigap policy with coverage considerably less than her HMO. The agent would have collected 60 percent or $516.60 for his day's work.

-- A 76 year old widow who shows serious signs of dementia has no family support and loves to have visitors. She also is unable to say no to insurance agents. Her banker asked the county benefit specialist to investigate when this woman wa over drawing her accounts due to a number of large checks written to insurance companies. During a two year period, this woman had bought 15 different insurance policies. Two other additional Medicare supplements had recently lapsed. The policies included seven Medicare Supplements, one daily indemnity, five life insurance and two cancer policies. . . Several agents switched her regularly every year to either a new company or a new policy for her Medicare supplement. Other agents sold her one of each kind of policy. With the assistance of the benefit specialist and the Office of the Insurance Commissioner some money was recovered however most of the policies lapsed or were canceled.

December 19, 1989

Chairman STARK. Thank you very much.
Ms. Long.

STATEMENT OF BETTY JANE LONG, MEMBER, NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS, MERIDIAN, MISS.

Ms. LONG. Thank you, Mr. Chairman.

I am Betty Jane Long from Meridian, Miss., and a member of the National Legislative Council of the American Association of Retired Persons.

Chairman STARK. From the home of our distinguished colleague, Congressman Montgomery.

Ms. LONG. I wanted to say that.

Chairman STARK. I'm glad you did.

Ms. LONG. Thank you.

Chairman STARK. Thank you very much. He's a very, very good tennis player.

Ms. LONG. He's been a very close friend of mine for many years.

If I might take just one moment, sir, I would like to thank you for the effort that you put forward in passing the catastrophic care legislation. And to say that I share some of the wounds and slings and arrows that I think this committee does the difference being that I was an unpaid volunteer for AARP, who attempted to explain the program in some places where I should not have been. That's another story also.

But I do want to say the reason I was in that position is because I was reared to believe that those of us that have good health and who are able to make our livings owe a debt that we can begin to repay by lending a hand to those who are, as Mrs. Johnson said in her opening statement, vulnerable. It is these people, made vulnerable because of physical or mental handicaps brought on by aging, that make this hearing you are holding today so important. And my hope is that all of us here, those who have testified and those to come, have the same idea about protecting the vulnerable.

I also want to commend you, Mr. Chairman—let me just say one other thing. I have a bad habit of this, and I apologize in the beginning. But I've got a handicap that your other witnesses don't have. And that is one probably shared by Sonny Montgomery—I'm from Mississippi and it takes me longer to say things. I did not learn to talk fast.

Chairman STARK. I noticed that you made yes a three-syllable word. It sounded just like Sonny.

Ms. LONG. That's what happens, and I apologize for that. But I don't have time to correct it today.

Chairman STARK. Well, don't let that red light scare you. You just go right ahead.

Ms. LONG. OK. I want to thank you, Mr. Chairman, for proposing your own legislation to protect consumers who purchase medigap insurance.

I also want to commend this committee for responding quickly to critical warning signs in the Medicare supplemental insurance market by holding these hearings.

The steep and persistent increases in Medicare supplemental insurance premiums are a continuing source of anxiety for older Americans.

With the repeal of the Medicare Catastrophic Coverage Act, older Americans are dependent on private supplemental insurance to fill the many gaps in Medicare.

As premiums continue to rise faster than Social Security cost-of-living increases, Medicare supplemental insurance is becoming increasingly unaffordable for many older people. Increases in supplemental insurance premiums reflect the overall growth in health care costs, and in particular the growth in Medicare cost.

Between 1983 and 1988, Medicare expenditures increased by an average of 9.1 percent per year. In 1990, the part A deductible increased over 5 percent. And preliminary data tells us that that in 1989 the part B program increased roughly 12 percent.

In addition, cost trends for supplemental insurance policies often are higher than Medicare cost trends because sicker individuals tend to buy more insurance.

In 1990, supplemental insurance policies bear, once again, the cost of long hospital stays and a number of other benefits that were provided in 1989 by the Catastrophic Coverage Act. In fact, estimates are that repeal resulted in an increase of $4 to $6 per month in supplemental premiums costs over what was originally estimated.

Insuring that Medicare beneficiaries receive a fair return on their insurance investment is a high priority in this era of rapidly increasing health care costs.

AARP supports vigorous enforcement of loss ratio standards to assure that all insurance companies pay a reasonable share of premiums back to their policyholders in benefits.

Very important in this regard will be careful monitoring of actual loss ratios which must be reported on all policies beginning in 1990. Where loss ratios are found to fall short of the mark, and where companies and States do not move immediately to bring policies into compliance, Federal action will be an essential and perhaps the only recourse.

AARP also believes that the Congress should examine the adequacy of the current 60 to 65 percent loss ratio standard for individual policies. A review should reveal insurance companies' administrative costs and profits, as well as the efficiency and appropriateness of their sales, administration, and distribution practices. This information should be used to evaluate the present standard.

Regulating insurance practices, however, will not address the fundamental reason for increasing premiums—rapidly rising health care costs. Unless this Nation can bring the cost of health care under control, more and more Americans, young and old, will be unable to afford health insurance to protect themselves from the risk of large health care costs.

Important to this cost containment strategy will be assessment of the appropriateness and effectiveness of common medical practices. Implementation of the physician-payment reform package enacted last year, and public education about health care costs that will help individuals to understand why health care costs are out of control and what they, as consumers, can do about it.

Let me now turn to consumer protection in the medigap market. Marketing abuses, such as duplication of coverage, unnecessary replacement of adequate coverage, high pressure sales tactics, misleading advertising, and poor value products appear all too often. The National Association of Insurance Commissioners has made major improvements in this area of the last several years. AARP strongly supported these reforms, and we hope that they will significantly reduce the types of sales abuses that have occurred.

We urge this committee to watch closely over the next several years to assess the adequacy of these reforms.

Consumer protection must also extend beyond these standards. Older consumers are confused about both their coverage under Medicare and about their supplemental insurance premium benefits.

We believe that both the Federal and State Governments must give far greater emphasis to providing consumers with better information about Medicare and available supplemental coverage.

Essential to this effort is standardizing the way insurers describe and present policy benefits so that consumers' choices are clearer. This can and should be done without preventing insurers from developing coverage for new and useful benefits, such as home health care and preventive care.

Over the long run, we urge this committee to be prepared to examine the appropriateness of age rating and medical underwriting. While these traditional insurance practices cannot be dismissed out of hand, they should not be allowed to segment the market in such a way that a growing number of people will be excluded from coverage because of health problems and inability to afford premiums for policies that set rates based on age.

In conclusion, and I know you are glad of that, it is particularly important to note that as long as Medicare contains significant limitations and coverage gaps, the public will continue to seek supplemental coverage. Accordingly, the Federal Government has an obligation to assure that affordable supplemental coverage is available.

Enforcing actual loss ratios and the new consumer protection standards approved by the NAIC are fundamental to this effort.

Similarly, public education can help ensure that consumers can make informed judgments about the cost, quality and adequacy of their health care coverage. A long-range view of the medigap insurance marketplace, however, requires going beyond these immediate steps to examine basic marketing practices.

Thank you, Mr. Chairman.

[The statement of Ms. Long follows:]

STATEMENT OF BETTY JANE LONG, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman, members of the Subcommittee, I am Betty Jane Long, from Meridian, Mississippi and a member of the National Legislative Council of the American Association of Retired Persons. I want to thank this committee for responding quickly to the critical warning signals in our health care market, in general, and in the Medicare supplemental insurance market specifically, by holding these hearings. Undertaking a careful investigation of the reasons behind increasing Medigap costs, putting cost containment strategies into place, and seeking appropriate answers to marketplace questions that will shape the Medigap industry in future years are essential to keeping necessary Medicare supplemental insurance affordable to those who need it.

My testimony will focus on immediate steps that are needed to constrain health care cost increases; the importance of public information and education in guarding against marketplace abuses; and the impact that traditional insurance practices, such as age rating and medical underwriting, will have on the affordability and availability of Medigap insurance in the future.

Increasing Health Care Costs

The steep and persistent increases in Medicare supplemental premiums are a continuing source of anxiety for older Americans. With the repeal of the Medicare Catastrophic Coverage Act of 1988, older Americans are dependent on private supplemental insurance to fill the many gaps in Medicare. As premiums continue to rise faster than Social Security cost-of-living increases, Medicare supplemental insurance is becoming increasingly unaffordable for many older people, especially those living on relatively fixed incomes.

Increases in supplemental insurance premiums reflect the overall growth in health care costs and, in particular, the growth in Medicare costs. Between 1983 and 1988, Medicare expenditures increased by an average of 9.1% per year. For 1990, the Medicare Part A deductible increased over 5 percent-- which directly increases the cost of most supplemental insurance policies. In addition, data for the first 10 months of 1989 show that Part B costs increased by about 12 percent over 1988 levels. Since supplemental policies pay a percentage of Part B allowable charges, these policies are subject to the same, or higher, cost trends than the Part B program. Cost trends for supplemental insurance policies often are higher than Medicare cost trends because "sicker" individuals tend to buy more insurance coverage than "healthier" individuals.

In 1990, supplemental insurance premiums also will go up because of the repeal of the Catastrophic Coverage Act. Supplemental insurance policies will bear once again the costs of long hospital stays, and in some cases long skilled nursing home stays, that were covered in 1989 by Medicare. Estimates are that the repeal of the Catastrophic Coverage Act will increase supplemental policy premiums by about $4.00 to $6.00 per month.

Need for Close Scrutiny of Rates

Medicare supplemental premium increases must be closely scrutinized to ensure that older people receive a fair return for their insurance investment. Past studies by the General Accounting Office have documented numerous instances where insurers have failed to meet minimum loss ratio standards, thereby offering poor value to their policy holders. AARP supports vigorous enforcement of loss ratio standards to assure that all insurance companies pay a reasonable share of premiums back to their policyholders as benefits.

In response to a requirement by the National Association of Insurance Commissioners (NAIC), companies are required to report their actual loss ratios beginning in 1990. Careful scrutiny of this data over the next two years is a must to ensure compliance. Where loss ratios are found to fall short of the mark, and where companies and states do not move immediately to bring the policies into compliance, then federal action will be an essential--and perhaps only--recourse.

AARP also recommends that the Congress take a close look at the adequacy of the current loss ratio requirement for individual policies--now set at 60 percent to 65 percent. Because for many older Americans Medicare supplemental insurance is a necessity, the cost of coverage, its accessibility to consumers, and efficiency in the marketplace are all critical factors in determining whether administrative costs or profits are excessive. The Association believes that an examination by the General Accounting Office of insurance companies' current administrative costs and profits, as well as of the efficiency and appropriateness of the ways in which these companies sell, administer and distribute their policies should be undertaken promptly to assist the Congress in setting an appropriate minimum loss ratio for these policies.

Controlling Health Care Costs

Regulating insurance practices, however, will not address the fundamental reason for increasing premiums: rapidly rising health care costs. Between 1984 and 1989, Medicare Part B expenditures increased 90 percent, an average of 14 percent per year. The Part B premium for Medicare beneficiaries has increased 91 percent over the last five years. Unless this nation can bring the costs of health care under control, more and more Americans, young and old, will be unable to afford health insurance to protect themselves from the risk of large health care costs.

The federal government has a vital role to play in controlling health care costs. Perhaps most important is providing support for research to assess the appropriateness and effectiveness of common medical practices. Congress undertook this effort last year as part of its Physician Payment Reform package which was enacted as part of OBRA 1989. Although the short term effects of this effort may be small, over the longer term, the significant expansion of research into appropriateness and effectiveness of medical practices holds the promise to fundamentally improve the quality of medical care for all Americans while at the same time eliminating enormous waste in the health care system.

Public information and education about health care costs also are critical. Individuals must begin to understand why health care costs are out of control and what they, as consumers, can do to lower health care expenditures. The federal and state governments, along with consumer groups like AARP, have a responsibility to begin to inform consumers about the health care system, including how it is financed, why costs are increasing, and what they can do to be more prudent purchasers of health care.

Consumer Protection

Unfortunately, the sale of Medicare supplemental insurance has too often been associated with a number of marketing abuses: duplication of coverage, unnecessary replacement of adequate coverage, high pressure sales tactics, misleading advertising, and poor value products. AARP has worked on both the federal and state levels for the passage of laws and regulations to correct these abuses. We have seen some progress recently.

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Two years ago in conjunction with the Catastrophic Coverage Act, Congress required that advertising for Medicare supplement insurance be filed with state insurance regulators, and extended the "free look" period for supplemental insurance purchasers. In these last two years, the National Association of Insurance Commissioners (NAIC) has substantially improved its Model Act and Regulations for Medicare supplemental insurance. Among other reforms, the NAIC has

- increased the minimum loss ratio for group-sponsored Medicare supplemental insurance sold through the mail from 60 percent to 75 percent;
- required insurers to meet <u>actual</u> as well as <u>projected</u> loss ratio standards;
- required increased reporting by insurers of financial results;
- required insurers to put in place procedures to avoid over-insurance and duplication of coverage;

- prohibited exclusions for preexisting conditions when one Medicare supplement policy is replaced with another;
- required policies to be "guaranteed renewable;" and
- established limitations on compensation to insurance agents in order to reduce incentives to "churn" coverage.

AARP strongly supported these reforms, and we hope that they will significantly reduce the types of sales abuses that have historically occurred in this market. We would urge this Committee to watch closely over the next 2 to 5 years to assess the adequacy of these reforms.

In addition, AARP believes more could be done to make Medicare supplemental insurance policies easier to understand and to compare. Standardizing the way insurers describe and present policy benefits in both advertising and policy forms would greatly enhance product comparability. Presently, policies use different terms to describe the same benefits (e.g., "balancing billing" or "excess charges.") Further, a more uniform format for presenting benefits would permit consumers to do side-by-side comparisons of policy benefits. The recent improvements made by the NAIC to the outline of coverage are a good start, but more uniformity in advertising material such as descriptive brochures, could be helpful. AARP believes these changes would make choices clearer to consumers without preventing insurers from developing coverage for new benefits such as home health care and preventive care.

Consumer Education and Counseling

Unquestionably, older consumers are confused about both their coverage under Medicare and about their supplemental insurance benefits. Medicare is a very complex program, and, Medicare supplemental coverage can also be difficult to understand since it complements Medicare's complex benefit structure. We believe that both the federal and state governments must give far greater emphasis to providing consumers with better information about both Medicare and available supplemental insurance coverage. The best method of controlling fraudulent marketing practices and other sales abuses is to provide purchasers with sufficient information to let them make informed decisions about their health care coverage needs.

Several states, including Washington, California, and North Carolina, have created programs in which trained volunteers provide information and assistance to older people with questions about health insurance. Such programs can provide older consumers with access to a knowledgeable, independent source of information about Medicare and supplemental insurance coverage. These programs can help consumers to compare supplemental insurance options, to understand the terminology, conditions and limitations of insurance policies, and to better assess their real need for supplemental insurance protection. And, as interest in long term care insurance grows, consumer education and counseling programs could play an invaluable role in assisting older persons to understand this new--and complicated--insurance option.

AARP urges this Committee to consider ways to create consumer education and counseling programs in all states. One option would be to work with state insurance and/or aging departments. The most important point is that extensive consumer education is the most effective mechanism to combat fraudulent and abusive marketing practices.

Long Term Issues for Medigap

Current concerns about the supplemental insurance market focus on premium increases and marketing practices, but other issues will increasingly draw legislative and regulatory scrutiny. As premiums for Medicare supplemental insurance rise, insurers are looking for ways to offer lower-priced coverage to select populations as a method of increasing market share. The use of such traditional insurance practices as health screening and demographic rating (i.e., rates based on age, and location within a state) are becoming more and more common. While these practices may be actuarially sound, the resulting market segmentation can give rise to many of the problems now found in other parts of the health insurance system. As health underwriting becomes more common, individuals with health problems will find it increasingly difficult to find coverage--- or to switch coverage if they are dissatisfied. Premiums which increase with age can significantly affect the ability of the very old to maintain coverage. If these practices come to dominate the market place, we can expect that a growing number of people will have difficulty finding and maintaining affordable coverage.

We are not here today to suggest that all these practices are necessarily inappropriate in this market or that they should all be eliminated. But what we are suggesting is that in addition to focusing on current abuses and needed reforms, Congress, as well as state legislative bodies, must address the future role of supplemental insurance and how the supplemental insurance market should operate. Older people view Medicare supplemental insurance as a necessity, and often make significant sacrifices to buy coverage. As long as Medicare contains significant limitations and coverage gaps, the public will continue to seek supplemental coverage. Accordingly, we have an obligation to assure that affordable supplemental coverage is available.

Conclusion

In the absence of Medicare coverage of catastrophic health care costs, Medicare supplemental insurance will play a very important role in older Americans' ability to obtain adequate protection against increasing health care costs. AARP applauds your scrutiny of Medigap premium increases and consideration of improved standards that would protect consumers from excessive premiums as well as marketplace abuses. These are essential and immediate steps toward consumer protection.

We also encourage you to consider what the Medicare supplement insurance marketplace will look like in future years if market segmentation trends continue. Supplemental insurance will quickly become both unavailable and unaffordable for those who need it most if we do not address these trends.

However, it is important to note that while the repeal of the Medicare Catastrophic Coverage Act is one component--and a significant one--of increasing Medicare supplement insurance rates that we are observing this year, and the aging of the population accounts for a small percentage of the increase, the upward spiral of health care costs overshadows both of these factors. Escalating costs, whether paid out-of-pocket or through insurance premiums, inevitably translate into insurmountable financial barriers to essential medical services, particularly for society's most vulnerable members. AARP applauds the efforts of this Committee and the Congress to address rising health care costs. We look forward to continuing to work with you on issues that relate specifically to Medicare supplement insurance as well as on the all-important issues of health care costs.

Chairman STARK. Ms. Long, thank you very much.
Our next witness, Ms. Burns.

STATEMENT OF BONNIE BURNS, CONSULTANT, HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM, SCOTTS VALLEY, CALIF.

Ms. BURNS. Yes. Thank you, Mr. Chairman, members of the committee.

As a consumer advocate, I appreciate the introduction of your bill.

I am a consultant to the State Health Insurance Counseling and Advocacy Program in California, known as HICAP, and to several of the 24 contracting local agencies. HICAP provides insurance counseling, billing assistance, and legal advocacy, using professional staff and 6,000 trained volunteers.

Medicare supplement insurance has a long and checkered history. At the beginning of the last decade, the Congress passed legislation known as the Baucus amendment. This amendment was responsible for the adoption of minimum benefit standards and consolidated benefits in a single Medicare supplement policymaking the purchase of more than one policy unnecessary.

The legislation also included a provision to prevent duplicative coverage. Unfortunately, the definition of duplicative coverage was flawed and later led to widely reported abuses that escaped Federal or any other prosecution due to that langauge.

Duplication is defined as coverage that will not pay because another policy which is in force will pay the same benefit. After Baucus, companies simply removed the prior coordination of benefits language, and now all policies in force will pay regardless of other coverage.

The beginning of this decade is an appropriate time to tackle the next step which has been described as standardization by some or simplification by others. Regardless of the term used to describe the reform, reform is undisputedly necessary.

In California, there are more than 200 different Medicare supplement policies available to consumers. And companies have been unbelievably creative in their choice of language to describe the benefits of their policy, and have seized on the most insignificant details in order to distinguish their policy from the flood of choices faced by consumers.

In the Medicare supplement market, competition has been the source of the problem rather than the solution. Eighty-two percent of all seniors have at least one Medicare supplement coverage. The real issue is replacement of coverage in an intensely competitive and saturated market where a virtual parade of agents show up to sell coverage to a single Medicare beneficiary.

Attached to my testimony is a political cartoon which appeared on the editorial page of the San Jose Mercury News, along with an editorial calling for reform in the sale and marketing of insurance to seniors. It accurately depicts what many seniors describe when they respond to mailings that offer to provide them with more information on their Medicare benefits.

Policies are purposely incomprehensible in their langauge and construction. They defy side-by-side comparison, and even singly are impossible for consumers to understand.

To illustrate the difficulty that seniors encounter when trying to choose coverage, I have prepared a paper entitled "Part B Terminology," which is included in your materials, and is after page 7 of my testimony.

The language used to describe a single benefit to supplement Medicare was taken exactly as it is stated in the policy from each of these six companies. Even though many of you have legal training and are familiar with dense legal langauge, I anticipated that this might be difficult for you to understand. So there's a page attached which uses a dollar figure example to show you exactly what each of these plans is attempting to describe and what it would actually pay a beneficiary.

I have also included several policies which have been analyzed by our statewide insurance counseling program to illustrate the difficulty of even boiling down the relevant factors to a form which can be used to compare several different policies the consumer might be interested in purchasing.

The form is the result of more than a year of debate between the State program and 24 contracting agencies that deliver the local HICAP services. If knowledgeable people cannot agree on the relevant pieces of information to adequately compare policies, then it is foolhardy to expect consumers to be able to do so.

When consumers cannot readily understand what they are purchasing and what it will pay, they fall prey to whatever an insurance agent chooses to tell them. Very often, they tell them that they need no less than six different policies, and proceed to sell them not only a Medicare supplement but the full array of garbage policies.

Agents tell people that they need hospital indemnity plans to help pay expenses that neither Medicare nor the supplement will pay. At the same time, they also sell them a surgical plan to cover costs that Medicare and a supplement will pay. Then they sell them accident insurance and cancer insurance, an even small value life insurance policies to pay their final expenses.

It is outrageous to expect elderly people to have skills for reading and analyzing insurance policies that are more advanced than the rest of the population. Standardization of these policies is long overdue. This is not a radical concept. Fire insurance policies were first standardized in 1868, and for many of the same reasons I have cited here. A jurist from that period speaks about the inability of man to understand the provisions of the policy of the period without laborious study, and "that just the perusal of a policy was physically difficult, painful and injurious."

More than 100 years later, it is still a true statement.

Several billion dollars are wasted by consumers every year when they cannot determine what their policies will pay. Companies and agent have collected enormous profits resulting from this confusion and the inability of consumers to make informed choices.

Consumers have consistently had to rely on agents for information about the relative value of their coverage, and have spent billions of dollars unnecessarily when agents exploited that trust.

Premium increases, by the way, are a fact of life. Deductions in those premiums are not. While there can be honest debate about the form that standardization should take, there can be no argument that these reforms are necessary and long overdue.

The industry has heard the same complaint the Congress has heard for the last decade. Instead of facing up to the problem, they have consistently denied the problem. Service used to be an important word in the insurance industry. It has been replaced with denial, stonewalling, and obstruction. Whenever abuses are cited and reforms are proposed. The industry has no one else to blame for the result which brings us here today.

I urge you to help lighten the burden of consumer confusion by limiting the endless array of insignificant and often illusory choices that allow predatory practices to flourish in this intensely competitive market.

Thank you for the opportunity to testify today.

[The statement of Ms. Burns follows:]

BONNIE BURNS
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21 LOCKE WAY
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408-438-6677

MARCH 13, 1990

Mr. Chairman, members of the committee, I am a consultant to the state Health Insurance Counseling and Advocacy Program in California known as HICAP, and to several of the 24 local contracting HICAP agencies. HICAP has documented savings of more than four and one half million dollars for 5,000 of the 140,000 people served by the program in the last fiscal year. HICAP provides insurance counseling, billing assistance and legal advocacy using professional staff and 600 trained volunteers.

Medicare Supplement insurance has a long and checkered history. At the beginning of the last decade the congress passed legislation known as the Baucus amendment. The practice of the industry during that period resulted in selling three different types of polices to supplement the benefits of Medicare. Seniors were sold a hospital plan, a surgical plan and a medical plan, all to supplement Medicare. The Baucus amendment adopted minimum benefit standards and consolidated benefits in a single Medicare supplement policy making the purchase of more than one policy unnecessary.

After that date all polices sold as Medicare Supplements had to contain certain minimum benefits. The legislation also included a provision to prevent duplicative coverage. Unfortunately, the definition of "duplicate coverage" was flawed and later led to widely reported abuses that escaped federal, or any other, prosecution due to that language.

Duplication is defined as coverage that will not pay because another policy which is in force will pay the same benefits. Prior to the passage of the Baucus amendment policies contained coordination of benefits language and the federal language would have prevented the selling of duplicative policies. After Baucus companies simply removed the coordination of benefits language and now all policies in force will pay benefits regardless of other coverage. Although seniors have no intention of profiting from the reimbursement of their medical care, that is often the result when they have been sold duplicative polices in the belief that they need additional coverage.

The beginning of this decade is an appropriate time to tackle the next step which has been described as standardization by some, or simplification by others. Regardless of the term used to describe the reform, reform is undisputedly necessary.

In California there are more than 200 different Medicare supplement policies available to consumers. That does not include certificates available through master group policies written in other states which do not require filing approval under California state law. Companies have been unbelievable creative in their choice of language to describe the benefits of their policy. They have seized on the most insignificant details in order to distinguish their policy from the flood of choices faced by consumers.

During a recent trial in which several agents were prosecuted by a district attorney for overselling insurance to seniors, the judge asked incredulously how any person could be expected to understand these policies. In the Medicare supplement market competition has been the source of the problem rather than the solution. Eighty two percent of all seniors have at least one Medicare supplement policy.

Availability of products and coverage is overwhelming. The real issue is replacement of coverage in an intensely competitive and saturated market where a virtual parade of agents show up to sell coverage to a single Medicare beneficiary.

Attached to my testimony is a cartoon which appeared on the editorial page of the San Jose Mercury News along with an editorial calling for reform in the sale and marketing of insurance to seniors. It accurately depicts what many seniors describe when they respond to mailings that offer to provide them with more information on their Medicare benefits.

Policies are purposefully incomprehensible in their language and construction. They defy side by side comparison, and even singly are impossible for consumers to understand. To illustrate the difficulty that seniors encounter when trying to choose coverage I have prepared a paper titled Part B Terminology which is included in your materials. The language used to describe a single benefit to supplement Medicare was taken exactly as it is stated in the policy from each of six companies.

Even though many of you have legal training and are familiar with dense legal language I anticipated that this might be difficult for you to understand, so there is a page attached which uses a dollar figure example to show you exactly what each of these plans is attempting to describe and what it would actually pay a beneficiary. I think you can see from these examples that it is unrealistic to expect consumers to decode and understand the coverage promised by their policy and determine the benefit they can expect to receive.

I have also included several policies which have been analysed by our state wide insurance counseling program to illustrate the difficulty of even boiling down the relevant factors to a form which can be used to compare several different policies a consumer might be interested in purchasing.

You will notice several papers attached to each form as additional information necessary to accurately compare coverage. The form is the result of a more than a year of debate between the state program and the twenty four contracting agencies that deliver the local HICAP services. It is self evident that if knowledgeable people cannot agree on the relevant pieces of information to adequately compare polices that it is foolhardy to expect consumers to be able to do so.

The confusion created by these impossible choices has resulted in egregious sales abuses that have been the subject of media coverage and federal hearings for more than a decade. It also helps to explain why seniors will buy multiple and duplicative polices in an effort to protect themselves from financial ruin resulting from the cost of medical care.

When consumers cannot readily understand what they are purchasing and what it will pay they fall prey to whatever an insurance agent chooses to tell them. Very often they tell them that they need no less then six different policies and proceed to sell them not only a Medicare supplement but the full array of garbage policies.

Agents tell people that they need hospital indemnity plans to help pay expenses that neither Medicare nor the supplement will pay. At the same time they also sell them a surgical plan to cover costs that exceed what Medicare and a supplement will pay. Then they sell accident insurance and cancer insurance and even small face value life insurance policies to pay their "final expenses." Agents revisit these elderly consumers at the first hint that anything has changed, or may change, under Medicare to sell them something different with complete disregard for the compulsory adaptability of the present Medicare supplement.

It is outrageous to expect elderly people to have skills for reading and analysing insurance policies that are more advanced then the rest of the population. Seniors, like most people, depend on agents for their information about insurance and are totally without the ability to challenge that information or to protect themselves from predatory practices.

Standardization of these policies is long overdue. This is not a radical concept. Fire insurance polices were first standardized in 1868 for many of the same reasons I have cited here. A jurist from that period speaks about the "inability of men to understand the provisions of the policies" of the period without "laborious study", and that just the "perusal of a policy was physically difficult, painful and injurious." More than one hundred years later it is a true statement applicable to many types of insurance.

Several billion dollars are wasted by consumers every year when they cannot determine what their policy will pay. They may change their coverage unnecessarily several times a year, or purchase duplicative coverage in an attempt to prevent their own impoverishment from the high cost of medical care. Companies and agents have collected enormous profits resulting from this confusion and the inability of consumers to make informed choices. Consumers have consistently had to rely on agents for information about the relative value of their coverage, and have spent billions of dollars unnecessarily when agents exploited that trust.

While there can be honest debate about the form that standardization should take there can be no argument that these reforms are necessary and long overdue. The industry has heard the same complaints the Congress has heard for the last decade. Instead of facing up to the problem they have consistently denied the problem.

The industry knows who the bad actors are and they are well aware of the problem. Their failure to set and enforce high industry standards can be measured by the gathering storm of consumer dissatisfaction and mistrust evidenced by the passage of Proposition 103 in California and its attempted replication in many other states.

Service used to be an important word in the industry. It has been replaced with denial, stonewalling and obstruction whenever abuses are cited and reforms proposed. The industry has no one else to blame for the result which brings us here today.

I urge you to help lighten the burden of consumer confusion by limiting the endless array of insignificant, and often illusory choices that allow predatory practices to flourish in this intensely competitive market.

Bonnie Burns

BONNIE BURNS
MEDICARE SPECIALIST
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SUBJECT: PART B PAYMENT TERMINOLOGY

Six plans from six companies were analysed to determine IF the plan covered charges under Part B and HOW that benefit was described and paid. The language is stated exactly as it was in the policy. Consumers are expected to read their policy, understand the benefits purchased and be able to determine what and how the company will reimburse them for their medical expenses.

If you do not understand the benefit language an example of a medical expense and the dollar figure that would be reimbursed under each of these six plans is attached to assist you.

Gerber 65 Plus Series IV Medicare Supplement Policy

Pays all -100% - of the Actual charges that remain after Medicare pays 80% of the charges they consider to be "Reasonable"...up to a maximum amount equal to Medicare's payment.

Underwriters Life Insurance - Senior Care Medicare Supplement

PHYSICIAN'S CHARGES ; We will pay 25% of what Medicare pays (100% of the Medicare co-payment amount) under Part B of Medicare for physicians, surgery and outpatient charges. Outpatient includes your hospital, physicians' office, clinic, ambulatory surgical center or hospital emergency room or outpatient department.

-OPTIONAL BENEFITS -

*Catastrophic Medical Expense Benefit ; We will pay 100% of all excess charges above the Medicare Eligible Expenses up to 100% of the usual and customary charges** after an out-of pocket amount of $200.00 the first year, $100.00 the second year; $0.00 the third and later years.

**Usual and customary charges means the actual expense, but not to exceed the average charge made for similar services or supplies in the locality where the service or supple is furnished, taking into consideration the nature and severity of the injury or sickness suffered by you.

Pioneer Life Insurance The Ultimate Protector Medicare Supplement

Pays 100% of Covered Expenses not paid by Medicare for medical and outpatient expenses after you have paid the annual Medicare Part B deductible. *Covered expenses are the incurred expenses UP TO 180% of the Medicare Allowable Charge.

United American MAXC

We will pay the following benefits for the expense incurred by you that is approved under Medicare Part B: The coinsurance amount not to exceed 25% of the amount paid by Medicare.

ADDITIONAL MEDICAL EXPENSE BENEFIT

We will pay benefits for Medicare Part B Excess Expense as follows: After the first $200.00 of Excess Expenses you incur in a calendar year, we will pay 80% of each subsequent Excess Expense. * Any expense incurred over 150% of the Medicare Part B approved amount shall not be considered Excess Expense.

American Integrity MMS 84

This policy pays 20% of approved charges after a $75.00 calendar year deductible and 80% of approved excess charges after a $200.00 calendar year deductible. *Approved excess charges is determined by taking the lesser of 150% of Medicare approved charges or the actual charges incurred if less than 150% of Medicare approved charges.

Providers Fidelity Life Insurance Senior-Care Medicare Supplement

Your certificate pays the difference between Medicare's payment and Usual and Customary charges (after a total $200.00 a year deductible) up to a maximum of Medicare's payment - NO LIMIT (Medicare Part B deductible of $75.00 included in Senior Care Deductible.) * Usual and customary charges: The range of charges within a geographical area for the specific services rendered and supplies furnished not to exceed the provider's actual charge.

PAYMENT EXAMPLE

MEDICAL CHARGE	APPROVED BY MEDICARE		PAID BY MEDICARE
$2,000.00	$1,500.00	80% =	$1,200.00

OWED BY MEDICARE BENEFICIARY

EXCESS CHARGE		COINSURANCE
$500.00	20% =	$300.00

GERBER PAYS $300.00 PLUS $500.00 OF THE EXCESS

The plan pays the entire excess charge amount because it does not exceed the amount that Medicare paid for this service.

UNDERWRITERS LIFE PAYS $300.00 PLUS $300.00 OF THE EXCESS

The plan applies an annual $200.00 deductible to the amount of the excess charges.

PIONEER LIFE PAYS $300.00 PLUS $500.00 OF THE EXCESS

In this example the amount charged is less than 180% of the amount approved by Medicare. If the charges had been greater than 180% of what Medicare approved the plan would ignore any amount of the excess charges above 180%.

UNITED AMERICAN PAYS $300.00 PLUS $200.00 OF THE EXCESS

The plan applies an annual $200.00 deductible to the excess charges and then pays 80% of those excess charges. If the charges had been greater than 150% of what Medicare approved the plan would ignore any amount of the excess above 150%.

AMERICAN INTEGRITY PAYS $300.00 PLUS $200.00 OF THE EXCESS

The plan applies exactly the same formula as United American shown above.

PROVIDERS FIDELITY PAYS $175.00 PLUS $500.00 OF THE EXCESS

The plan applies an annual deductible to benefits under Part B consisting of the $75.00 deductible used by Medicare PLUS an additional $125.00. An annual total deductible of $200.00 is subtracted from Part B expenses.

This example assumes that the $75.00 Medicare deductible has been met to make the example easier to understand.

Editorials/Letters

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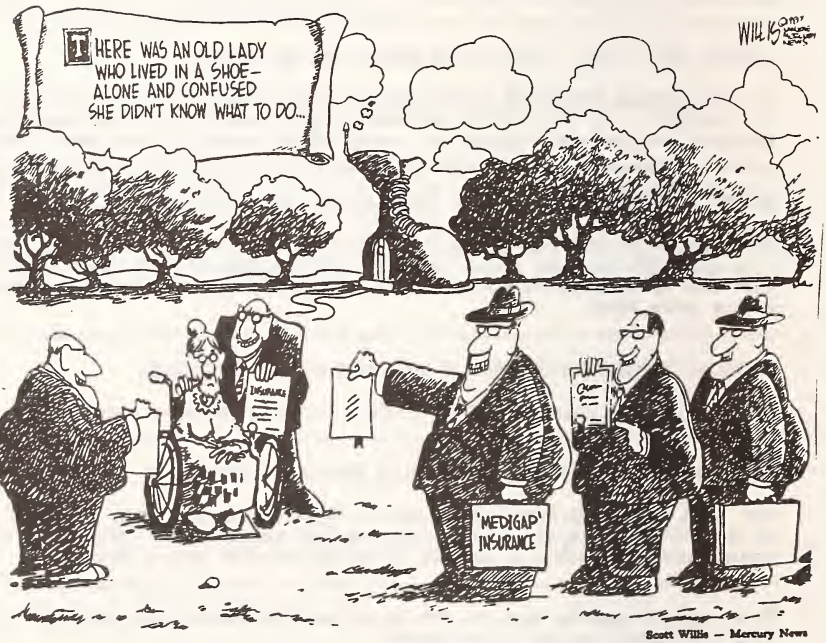

Scott Willis — Mercury News

Mr. COYNE [presiding]. Thank you for your testimony.

Mrs. Johnson.

Mrs. JOHNSON. Thank you. I wouldn't entirely agree with you on the grim way you portrayed the insurance industry, but I think there are a lot of difficulties in this particular area of marketing, and certainly evidence of abuse.

I do think that we have to take into account the impact of State mandates. My department of aging commissioner from Connecticut wrote me when we still thought the catastrophic legislation was going to stay in effect; that there would be no drop in Connecticut premiums because of new State mandates that had been passed that were going to push premiums up, even when we thought catastrophic would bring them down.

This is a complex market. State legislatures are very active and have a lot to do with premium rates. My particular concern is the issue of simplicity and clarity. Do you believe that it is wiser to adopt requirements at the Federal level that require uniform format and language, or to actually mandate standardized benefits and then allow riders or separate policies provide additional benefits?

I want to separate the policy format issue from the rate regulation issue. I believe they are different issues, and I believe it is important to analyze them separately.

Would you support a Federal override that would define the specific provisions in the policy? And would you also support a core program with latitude at the State level to add separate policies that were riders?

Ms. BURNS. I think that we need to do two things. We need to standardize the langauge because companies can now use langauge so differently to describe the same thing that no consumer can possibly decipher or decode what that means.

And, second, I think we need to narrow down some of the choices because they are based on such insignificant differences that they have no real market value.

Mrs. JOHNSON. Any of the rest of you?

Ms. SHEARER. I agree with that. And it's interesting to note that there are three States that have led the way, and I think that the subcommittee, and all of us can learn a lot from what the States of Minnesota, Massachusetts, and Wisconsin have done.

Wisconsin gives us the model of a core group of benefits, and then six optional riders, all with standard definitions.

Minnesota has a slightly different——

Mrs. JOHNSON. Excuse me. Is more than one company offering that plan in Wisconsin?

Ms. SHEARER. Actually Wisconsin publishes about a 12-page list that lists the companies and which options they offer. And there are certain options that have relatively few companies offering them. For example, the prescription drug benefit. But all options are offered by some group of companies.

In Massachusetts, they have actually grouped options into four different categories of benefit, ranging from relatively low to relatively comprehensive. And consumers basically can pick the level of comprehensiveness that they want without having to make 20 different decisions about how excess charges are defined, or what-

ever. They make broader choices. And the standards basically reflect the range of services that consumers want to buy.

Mrs. JOHNSON. And do different companies offer policies in each area so that they can compete on the basis of administrative excellence and service?

Ms. SHEARER. Well, in Massachusetts, the story, it's a little bit more complicated because, in Massachusetts, there is one company that definitely dominates that market and actually I think that the standards were written in large part around that company's policy.

I would rather look at the situation in Wisconsin where there is truly more competition. But the best example of all, and fortunately you are going to be hearing from the commissioner from Minnesota which I think is wonderful, in Minnesota, they have a combined approach where they have one basic policy with certain core benefits with four options that can be offered.

And then they also offer an extended coverage package. And in that policy you have the basic benefits plus all the options automatically included plus the catastrophic benefit. And because the insurance department has grouped the options like this, the consumers are able to compare the price of a similar product.

Say a consumer wants the most comprehensive policy. They can go and get the information to compare exactly identical policies. So it facilitates price competition.

Mrs. JOHNSON. Thank you.

Mr. COYNE. Mr. Levin.

Mr. LEVIN. Thank you. Let me focus, if I might, on issues relating to State control.

First of all, you heard me read from the Michigan booklet. And, Ms. Burn, you say in your testimony on page 3, about California, there are more than 200 different Medicare supplement policies available to consumers. That does not include certificates available through master group policies written in other States, which do not require filing approval under California State law.

If you would, describe briefly. What's the reach of California law over medigap policies? What can be controlled through California and what cannot be?

Ms. BURNS. Well, I've probably been one of the more spoken critics of the California Department of Insurance, and in my mind they've done an extremely poor job in this market. And when pressed to do so by consumers, have begun to take some action. But the issue of rates—first of all, California does not have rate setting authority so they cannot dictate rates to companies. They can enforce loss ratios. However, they have never done that.

The issue of discretionary groups is a group that forms outside of the State of California and writes its master policy in another State. They have automatic entry into something like 24 States without any approval of those policies, or any regulatory control over the certificates that are then sold in the State.

Mr. LEVIN. Is that a matter of Federal constitutional law or State preference?

Ms. BURNS. I think it's the way that this particular situation has evolved. I think originally groups were, employer groups or unions, and added to that we now have association groups such as AARP. But the fourth category is the most troublesome, and that is a dis-

cretionary group which is often a group formed by an insurance company. That group enjoys some of the very same regulatory protections of an employer group for entirely different reasons.

Ms. SHEARER. If I could just interject, the Federal Trade Commission over the years has tried to take action against abusive practices that cross State lines. The McCarran-Ferguson Act has been interpreted by the court so narrowly that as long as there is any sort of regulation, any attempt to regulate at the State level, the FTC is basically out of this market.

Mr. LEVIN. But I was focusing on the power of the States and whether they are hamstrung by the Constitution, by Federal court decisions, or why is there in the Michigan booklet the statement about the inability of Michigan to regulate certain types of policies?

Well, maybe we'll have to explore that further because, clearly, one of the issues here is not only whether there should be considerably more regulation, but who should undertake it?

I don't know if you have seen the testimony from the National Association of Insurance Commissioners, but I think you basically know their position.

They say, and you will hear it in more detail later, essentially, leave it to the States. We believe the NAIC and the States are responding in a very timely fashion to the enactment and repeal of catastrophic. They oppose this proposal because they believe that it will not address the concerns which have been identified by Congress and by the State. They believe that the bill, if enacted, will only contribute to an already confused elderly population.

Essentially, as I understand the testimony, it says leave it to the States. Now, why don't you tell us your feeling about that. Why are they wrong?

Ms. BURNS. We've left it to the States for more than a decade. And both the industry and NAIC have said let the States do it.

A decade later, the States have not done it. The States did not do Baucus, and the States will not do this.

California has done very little in this area. The department of insurance has to allocate resources, has to have the will, and a regulator must have the ability to understand these products. They are different than most other insurance products. They are an anomaly and don't operate by the same rules.

Practically any regulator who starts to specialize in this type of insurance will tell you the same thing. This doesn't happen in any other part of the industry. Why does it happen here?

And I submit to you that it happened here because of profit. If you look at the loss ratios and the enormous profitability of the products that are sold to seniors, and you look at the enormous commissions that are paid to agents in order to get a policyholder to buy the product of company A instead of keeping the product of company B, which they already have, it is an inescapable conclusion that these are very profitable products.

Mr. LEVIN. Ms. Shearer, what do you say, why not leave it to the States?

Ms. SHEARER. The States have been trying to regulate this for a long time. And I have to say I have respect for what the NAIC has tried to do recently. The regulations that they revised in December

were certainly a step in the right direction. But what we find is that the resources at the State level are inadequate to deal with this problem.

Many State insurance departments don't even have an actuary.

After years of exposes of this type of problem, it just seems inexcusable that companies still train agents the way they do, that loss ratios still continue to be very low in some cases. And we think that Chairman Stark's bill gets the right balance of really a complementary Federal and State role to deal with this problem.

This problem was caused really because of the design of the Medicare program, and we feel that that gives a special obligation to the Federal Government to make sure that the market is working smoothly.

Mr. LEVIN. Ms. Long, do you want to say anything to sum up? The red light is on.

Ms. LONG. OK. I would have to say to you, Congressman, that I am not as knowledgeable as these ladies on insurance per se. But I can tell you that, speaking for AARP, I cannot give you a personal opinion, and the association itself has not gone into the bill. They will. They are pleased that the bill has been introduced to open the door for this discussion. But they have not taken an official position. And I cannot give one.

Mr. LEVIN. Thanks.

Ms. LONG. But we are in favor of standardizing these policies so that people will understand.

Now, what the insurance commissioners intend to do, I don't know. But I think they can enforce it. In my State, they have already adopted these new standards. And I spoke recently with my commissioner, and he tells me that they are going to enforce them, and that they are working very hard, that they are holding public meetings for senior citizens to try to educate them. They are making an effort. But now whether it will be successful, I don't know. And as I said, I cannot take a position on this bill.

Mr. LEVIN. Thank you.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman.

I want to thank the panel for, I think, graphically illustrating the need for attention in this area. And I think my colleague from Michigan is absolutely right. The question isn't whether, but it's how we go about it. And that's the spirit of the questions I would like to ask you.

Ms. Shearer, you cited Minnesota, Wisconsin, and Massachusetts as States with good regulatory records in this area.

Would you consider those States to have regulations in place that would be better than, as good as, or not as good as, let's call them, the Stark standards in the legislation before us?

Ms. SHEARER. The Wisconsin approach is very similar to Chairman Stark's approach. But I must say there is one improvement in the Stark proposal.

As I understand it, the bill would require the companies to price the minimum benefit package separately. That is one thing that Wisconsin doesn't do. And I think that by pricing the minimum package separately, you can compare the price among different

companies for apples and apples, the same product. So that is certainly a step in the right direction.

I have just recently taken a hard look at different standardization approaches. And there certainly is room for difference of opinion. But, in weighing different things, in weighing limiting consumer choice somewhat versus simplifying the market to make it easier to make decisions, I really have come out thinking that the Minnesota type of approach is the best way to standardize the market.

And as I said, I do really think there is room for difference of opinion there.

Mr. CHANDLER. In those three States, are the insurance commissioners or whatever, are those elected positions in those three States, do you know?

Ms. SHEARER. I don't know. I don't believe they are.

Mr. CHANDLER. Well, the thought occurs to me, I know our State, Washington, has an elected insurance commissioner. And I have spoken with him on a number of occasions about this issue. And due to nothing other than pure raw political pressure, he is very much aware of this issue and is working on it.

Now, I don't know why you didn't include him in your list of States that are doing a great job. I intend to call him and ask him why not?

But, I wonder, are we better off with someone close to folks, someone elected like that, someone that you can literally drive to see in one day, you know, what I'm saying? Rather than someone off in Washington, D.C., difficult to reach, someone who is not elected directly—do you follow what I'm saying? Is there a tradeoff here? As you pointed out, if you standardize, then consumer choice is sacrificed, you weigh between those two. Same thing here.

Ms. SHEARER. I think if it is left to total State discretion, we are not going to get very much change from the type of regulation we have now with the NAIC taking a certain approach that does not standardize. They have done some good things. We will still have maybe a handful, maybe only three States, that have taken the approach of standardization.

Election of insurance commissioners can certainly help increase accountability to the public, but I do not think it guarantees that they get the right framework for regulating this market. It is very complicated. I think there is a strong argument for having it centralized and having some uniformity.

A lot of these policies are sold across State lines. If a consumer in New Jersey gets something in the mail from California, it would be nice if that consumer could compare it with other similar policies in New Jersey and be able to make up a good comparison of premiums.

Mr. CHANDLER. Well, one final question: do you think the concept of standardizing policies is a necessary concept to make sure that people are getting their money's worth? Is it possible to have perhaps some other regulatory standard to guarantee?

Ms. SHEARER. Well, there are other approaches. Increasing the minimum loss ratio helps assure that. But one of the foundations of a smoothly-running, competitive marketplace is an informed consumer.

Without standardization, I think that you just cannot escape the fact that consumers are going to be confused. And the more confused they are, the harder it is to get them to buy the high value policy because they cannot tell which is the high value policy. So in a sense I feel that standardization really has to be an ingredient of a smoothly working marketplace.

Mr. CHANDLER. I promised only one more. This is half of that other question.

I asked the other panel about consumer behavior in this field, and whether the price and comparison of insurance products seems to have anything to do with what consumers end up purchasing. What is your experience in surveys of your readers and so forth?

Ms. SHEARER. Well, Consumer Reports published an article last spring that rated several different medigap policies. And we found that the prices for similar policies vary dramatically. And this is because consumers do not have all the information they need.

They are at the whim of the agent who comes to their door. They do not have a document for the most part that lists different companies and different premiums.

Of course Wisconsin is an exception. They do give consumers that tool. So there is a lot of price disparity for similar products in this market.

Mr. CHANDLER. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Moody.

Mr. MOODY. Thank you.

As the only member on the panel from Wisconsin, I have enjoyed your description. We do have a good regulatory climate, regime. And we have had that for quite a while. However, we do have—my information indicates a number of policies do fall below the Baucus level of 60 percent. Not much can happen to them unfortunately.

Do you support the idea of tax or some other sanction against falling below 60 percent?

Any of you? Ms. Shearer.

Ms. SHEARER. It is certainly one policy option. I am not ready to say it is the only one certainly.

But I think that one key is to find someone responsible for enforcing the loss ratio. And I understand Wisconsin may be one State that does not have an actuary on the insurance department staff. I really do not understand how they can adequately enforce it with the resources that they are putting into it.

Mr. MOODY. Well, according to my information, the 1988 report of the Wisconsin Insurance Commission indicates that the loss ratios on individual accident and health policies, mostly medigap, in Wisconsin ranged from a high of 72 percent loss ratio to a low of 10 percent, with an average of 57 percent, slightly below the Baucus level, on average for all 352 insurers and an average of 59 percent, slightly below the Baucus level, for the 20 insurers which write 70 percent of the policies.

So it is not—we probably are one of the best States, and yet we have those loss ratio numbers that are on average slightly below the Baucus level of 60 percent.

Some of the companies in Wisconsin—I am sure elsewhere—have these huge front-end emoluments to the sales persons which are

$500 or more sometimes for a single sale of a new policy, which encourages twisting, encourages people to get off one policy and on to another, and high pressure tactics against senior citizens who are confused. So I appreciate your testimony very much, all three of you.

Is there something that Wisconsin should do that it is not doing? If we are one of the best States, what more do we need to do? Put teeth in the 60-percent rule?

Ms. SHEARER. I think that is probably the first thing. And I know Wisconsin also has a benefits program that provides counseling to senior citizens. And so they have taken that step, and that is unusual. Most States do not have such things.

Mr. MOODY. The Senator from Wisconsin, Senator Kohl, had hearings in the State about this matter. He has introduced a bill to provide a hotline, provide a Federal hotline to advise people, for counseling for medigap. Do you think that makes sense?

Ms. SHEARER. Yes. I think he is also a cosponsor on Senator Pryor's bill, which would provide grants, matching grants to States who are developing counseling programs similar to the one that Ms. Burns works for. And we think that makes so much sense.

Actually we are in the process of doing a survey of the 12 States with counseling programs. And the feedback that we have gotten so far is incredibly positive.

These programs are saving senior citizens a lot of money. When the senior citizen can sit down with an objective source of information, it just makes a tremendous difference.

Mr. MOODY. Right. Thank you very much.

Chairman STARK. Thank you. I want to thank the panel.

I do have one concern. We will hear later today about the standardizing benefits as a threat to creativity. Now, I will stipulate that limiting creativity would probably have done something to help these victims of overselling that are attached to Ms. Shearer's testimony. If you could find more ways to chisel, cheat, and bamboozle delicate elderly people out of $6,000, $10,000, $50,000, I am sure it will be these health insurance companies that will dream it up. If that is the kind of creativity this bill would stifle, I am sure the panel would say so be it.

However, in testimony, people will suggest that if this bill does tend to standardize benefits, such things as dental coverage, eye care, and health promotion plans, would be destroyed and that somehow this bill will stifle entrepreneurship and so forth. I guess I would ask each of you to address that.

Certainly I think one of the most comprehensive analyses of Medicare policies was done by Consumer Reports. I would like to know how important creative new benefits would be. I would like to ask the AARP, who I think has one of the better policies in the country, what do their members want in creative new benefits? Have you got a great demand out of your millions of members for creative benefits? Would creativity help restrain some of the concerns that Ms. Burns brings to us?

Do you want to just sort of comment in order? Do you want to comment first, Ms. Long, as to what is their dream for new creative benefits that are not now available from Prudential or through Prudential to your members?

Ms. LONG. The position at this time, Congressman, is that we want standardization in wording, in descriptions, in every aspect that will say to a person who holds two policies side by side, or three policies, this is the same benefit in each one, standardization, no words that with a one-word difference or two-word difference that would make it, you know, seem to be a different policy when actually it is the same thing. We want that type standardization.

But the AARP at this point does not want to eliminate the possibility for developing innovations in the market. And the benefits that are specifically spelled out in my testimony were the benefits for home health care, which are vital to many of our AARP members, and also for preventive care which we think will certainly keep down the cost of Medicare.

I think that is probably where we fall down the most, is preventive care. And we do not want to throttle the insurers to the extent that they will not be able to offer these new benefits.

Chairman STARK. Well then, I would ask Ms. Shearer whether that would be possible in your opinion under this bill and what other losses the public would suffer from lack of creativity or entrepreneurship?

Ms. SHEARER. I think it is really important that the creativity of insurers be harnessed. Creativity has not really served these consumers well so far. Five years ago, coverage for balanced billing had not been invented yet. And insurers came up with it. And because there was no centralized regulator watching over it, as Ms. Burns has described, the definitions for that coverage have been all over the place, making it virtually impossible for consumers to know what in heaven's name they are buying.

I think that the Government would have three opportunities for considering creative requests. First of all, new benefits could be considered, possibly not in this political environment, but should Medicare cover these benefits? That is question number one.

The second question under your proposal would be: should the benefits under discussion come under the basic policy?

And the third question: should it be included as a standard optional rider?

And I think your proposal allows some flexibility for the Government to consider new ideas that come up, but at the same time channeling these ideas so that a standard benefit could be considered.

Chairman STARK. Thank you.

Ms. Burns.

Ms. BURNS. Well, I have been doing this now for about 15 years. And I have yet to see the industry add creative new benefits to individually purchased policies. The type of benefits that you describe are available in California only in employer group-sponsored contracts or in some association contracts from some work-related activity.

The products that are sold to seniors on an individual basis have about five variations. So there are five things that can be carved out and covered separately. But that is the limit. They do not offer eyeglass coverage, they do not offer dental coverage, and they do not offer some of the benefits that many people would like to see included in a supplement.

I agree that limiting the creativity of the industry is more important at this point. So to that end, I would support what you are attempting to do in your bill.

Chairman STARK. Thank you very much.

I have a question for the record. And while I am sure that Ms. Long would be able to deal with this and dispose of it just in 30 seconds, rather than steer her away from her avowed purpose today, I am going to ask that—Ms. Long, I am going to ask you this question and submit it to you in writing, and ask you to ask your able staff at AARP to help send back a letter in response to this question.

Would you do that?

Ms. LONG. Yes, sir.

Chairman STARK. The question deals with the commissions earned by AARP from the sale of its medigap policies. And it is the questioner's understanding that these commissions are not treated as unrelated business income under the current tax provision.

Mr. Donnelly would further like to know why AARP would argue that the commission income is not subject to the unrelated business income tax and whether or not selling insurance is substantially related to the tax-exempt purpose. I think that the question will be clear. The Chair would appreciate it if you could respond to the committee to Mr. Donnelly's question.

Ms. LONG. Thank you for doing it that way.

Chairman STARK. Thank you very much.

[The following was subsequently received:]

AARP

April 13, 1990

Honorable Brian J. Donnelly
2229 Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Donnelly:

This letter is in response to a question which was asked on your behalf by Representative Stark regarding the tax treatment of income AARP receives from its group health insurance program. The question was asked at the Ways and Means Health Subcommittee hearing on March 13, 1990. The information presented below is similar to that which we provided the Subcommittee on Oversight of the Committee on Ways and Means at a hearing on the Unrelated Business Income Tax in June of 1987.

AARP's group health insurance program is one of AARP's oldest programs, established in the 1950's. The cost of proper health care has always been an especially critical concern of older Americans.

AARP pioneered the concept of group health insurance designed for older Americans. At the time the program was instituted, there was no such insurance generally available. Insurance companies were reluctant to enter this field because of the exposure to major risks and the lack of any precedent proving the viability of such insurance on a major scale. Dr. Ethel Percy Andrus, AARP's founder, was able to get a commercial insurer to take these risks and offer such coverage, with no health questions, modest pre-existing condition limitations, and reasonable identical rates for all members, whatever their age and wherever they resided. It was found that such insurance satisfied an important need of AARP's members, and AARP thereafter has continuously arranged for group medical insurance plans for its members.

Congress in 1965 passed Medicare, and commercial insurers began to offer supplemental group health insurance to older Americans. Despite these helpful developments, the need for AARP's program still exists among older Americans. Medicare is a limited program and leaves a considerable risk of financial burden on the participants. Compared to AARP's program, no other private program offers as comprehensive coverage for the cost, offers

such coverage so easily to so many people in need of it, or keeps pace as well with the rapid changes in the delivery of health care services and in Medicare reimbursement policies. This is demonstrated not only by the growth of the program (currently over seven million individual member insureds), but also by surveys conducted at AARP's expense by the independent consulting firm of Towers, Perrin, Forster & Crosby concerning whether, and to what extent the membership of AARP wants it to continue to sponsor this program. These surveys demonstrate emphatically that AARP's sponsorship of group health insurance is still of great importance to the membership.

AARP, through a trust established for this purpose, obtains group health insurance for its members by contracts with an unrelated commercial insurance company (currently, the Prudential Insurance Company of America). AARP selected the current insurance provider in 1981 with the assistance of the Towers, Perrin firm, which invited 64 companies to participate and reviewed proposals from 16 of those companies. AARP has a contract with Prudential establishing standards for premiums, loss ratios, claims services, and the insurance company's profit (which in no event can exceed 1.75 percent of earned premiums). AARP's objective in negotiating the contract is to see that it properly meets the needs of older Americans at as reasonable a cost and as high a quality as can be obtained.

Once the contract is in place (typically for a five year term), AARP monitors the promptness and quality of the insurance company's performance, makes expense/control audits of performance (including an actuarial audit through independent experts at least annually), engages in ongoing research to determine whether new benefits or other changes in the policies are needed or desirable, and, in general, serves as an "ombudsman" to see that complaints are adequately and quickly resolved. When, for example, in 1984 and 1985, claims experience proved to be more favorable than anticipated, AARP saw to it that insured members received substantial refunds of premiums.

AARP directly and through experts it hires, is constantly evaluating the intricate provisions of its health insurance policies and insisting on changes or new provisions which benefit the insured. AARP has the power and the expertise--and uses it--to be an effective bargaining agent for its members with the insurance provider. AARP has a unique position as the single most important organization that represents and protects the interest of older Americans in this field, not only in obtaining the best contracts for them, but also in setting the standard that other group health insurance programs must meet.

Thus, AARP's group health insurance program, from negotiation of the policies to monitoring its operations, directly promotes the social welfare of older Americans. AARP receives an administrative allowance, currently at approximately 3.3% of the premiums under the program. This is reported to AARP's entire membership in its annual reports, and to the Internal Revenue Service on AARP's annual Form 990, as income substantially related to AARP's social welfare purposes.

Our members might very well be better off if we had a national health program. They certainly would benefit from more extensive and comprehensive Medicare coverage. These are areas in which AARP's legislative advocacy efforts continue apace, as you well know, even though, if Medicare were so expanded, our members would not need so much supplemental health insurance. AARP has always been, and will remain, committed to such efforts.
If I can be of further assistance in this matter, please do not hesitate to contact me.

Sincerely,

Martin Corry

Martin Corry
Director
Federal Affairs

cc: The Honorable Pete Stark

Mr. STARK. I want to thank the panel very much for their participation. Before you go, I do have to suggest that Gail Shearer and my staff may have disagreed some on how we intended to disclose the price of the project, and whether or not the minimum benefits would be priced separately.

It has been brought to our attention that several areas of this bill need tightening up. So that if I can be accused of being too gentle on the health insurance companies, I would agree with that. We appreciate your suggestions for ways in which we can make this bill fairer. And I thank you for your participation.

Our next panel includes representatives from the medigap insurance industry. We are happy to welcome Alan Spielman, the executive director of government programs legislation for Blue Cross and Blue Shield, and Linda Jenckes, vice president of Federal affairs for the Health Insurance Association of America.

It is good to see you both back here. I anticipate your precise, unemotional destruction of the Stark bill in the time allotted you. Your prepared testimony will appear in the record. You may proceed to dismember the Chair in any manner your are comfortable.

Mr. Spielman, lead off.

STATEMENT OF ALAN P. SPIELMAN, EXECUTIVE DIRECTOR, GOVERNMENT PROGRAMS LEGISLATION, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. SPIELMAN. Thank you, Mr. Chairman.

I would like to confine my oral remarks to comments on the chairman's bill. And I would like to say at the outset that these are indeed preliminary comments. We are still looking at the bill and other approaches.

We are pleased that the chairman's bill focuses attention on the key problems of enforcement of minimum loss ratio standards, the sale and purchase of multiple medigap policies, which is a waste of seniors' money, the lack of appropriate regulation of low value dread disease and hospital indemnity policies, which are not medigap policies, and beneficiary confusion in making insurance decisions.

We are, however, concerned that the bill unnecessarily preempts State regulation in many respects and seeks to address the beneficiary confusion problem by having the HHS Secretary decide what benefits private insurers can include in their medigap policies, a move that we believe is not in the best interests of senior citizens or the Medicare program.

Let me elaborate. The problem in the medigap regulatory arena has not been the failure of States to adopt whatever rules and regulations Congress has asked them to adopt. The problem has been in enforcement. All the rules and regulations do not amount to a hill of beans, as Bogart might say, if they are not enforced. And there is no excuse for lax enforcement.

I would, however, make three observations. First, the Federal Government has never demanded enforcement of the medigap standards. The process used by the Federal Government to certify State regulatory programs has been a paper review, not a look-behind to assess how well the rules are being enforced.

Second, simply transferring certain regulatory functions from the States to the Federal Government does not solve the enforcement problem, it simply moves the problem. The Medicare program has a history of not devoting adequate resources to enforcement. We know that is the case in the Medicare contractor environment. We know that in the inspector general environment and for other program integrity functions.

If there are not enough Federal resources now to enforce provisions in which the Federal Government has a financial stake in ensuring compliance, will there be adequate resources to enforce new medigap rules where violations have no impact on Federal spending? We are skeptical.

Finally, the closer you are to the source of a problem, the better positioned you are to correct the problem. We believe that States, not the Federal Government, are in the best position to enforce medigap insurance standards. As a group, they need to do a better job. We think there is an important role that the Federal Government can play by requiring States to demonstrate the effectiveness of their programs in order to maintain their Federal certification.

Let me comment on standardization of medigap benefits. First, we believe there is a lot that can be done to help beneficiaries understand better the Medicare program and the choices available to them for medigap and long-term care insurance. Beneficiary education and counseling, while difficult indeed, is needed. Also, more uniformity in language and format would help, as the chairman's bill recognizes.

Federal prescription of benefit design would, however, reduce benefit choices and make it more difficult for insurers to provide innovative benefits or to adopt new designs that help to contain costs. We believe that part of the opposition to the Medicare Catastrophic Act was that beneficiaries did not want the Federal Government to dictate the benefit packages that they must purchase out of their own money.

In addition to this basic concern about federally prescribed benefit design, we have some practical concerns about the bill's proposed approach. Again, with no Federal dollars at stake, we question the priority that will be placed on this effort. We fear that insurers would have to go through significant delays and redtape to provide any innovation.

Moreover, the benefit package could be subject to restrictions or changes based on political or other concerns that are not directly related to beneficiary preferences for insurance coverage. For example, provider groups may lobby successfully for restrictions of the cost containment features of our plans or for mandated benefits that will increase medigap premium costs for all.

Also, the Federal Government might restrict benefits based on the view that beneficiaries should bear a greater share of their health care costs out-of-pocket.

Another observation I would make is, if I have done my math correctly, Mr. Chairman, the proposal for a minimum package plus 7 standard options still leaves 128 possible combinations of benefits, thus doing little to reduce confusion. It is also important to note that Medicare is a standard policy. And it is quite difficult, as you know, to understand Medicare and to communicate its provisions

to beneficiaries. I would not change places with one of our customer service representatives in a million years.

Finally, the proposed list of benefit options does not include preventative benefits which many medigap plans provide, as do many Medicare HMO risk contractors, and does not permit PPO, preferred provider network, arrangements.

Thank you, Mr. Chairman.

[The statement of Mr. Spielman follows:]

STATEMENT OF ALAN P. SPIELMAN, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman, I am Alan P. Spielman, Executive Director, Government Programs Legislation, of the Blue Cross and Blue Shield Association. I appreciate the opportunity to testify before this subcommittee on the subject of Medicare supplemental insurance. Blue Cross and Blue Shield Plans underwrite benefits to supplement Medicare coverage for about eight and one-half million beneficiaries, approximately 42 percent of all beneficiaries who purchase such coverage. About two-thirds of these beneficiaries have individual Blue Cross and Blue Shield coverage; the others are covered under group policies.

Our testimony today will focus on three issues:

1. The effect of repeal of the Medicare Catastrophic Coverage Act on private Medicare supplemental policies, with respect to both benefits and adjustments to premiums.
2. How the regulation of the Medigap market has changed as a result of recent action by the federal government and the National Association of Insurance Commissioners (NAIC).
3. Whether there is a need for additional federal regulation of the Medigap market.

Effect of Repeal on Medicare Supplemental Insurance

When the Medicare Catastrophic Coverage Act (MCCA) was repealed last November, the Medicare program was returned to its former design, and the very gaps in benefits that the catastrophic legislation sought to close were created anew.

Under MCCA, the government assumed the full liability for Medicare hospital costs exceeding one deductible per year. The government also covered up to 150 days of skilled nursing facility care, subject to beneficiary coinsurance during the first eight days. In addition, in 1990, Medicare was scheduled to assume the liability for all Part B cost-sharing for physician and other medical services over $1,370.

It was estimated by the Congressional Budget Office that the Medicare benefits added by MCCA would have cost $7 billion in 1990. To finance these benefits, the Congress found it necessary to increase the Part B premium and establish a new Medicare supplemental premium.

Since private insurance has traditionally filled in most or all of the gaps in Medicare coverage for acute care expenses -- hence the term "Medigap" -- it is expected that private insurers will respond to the repeal of catastrophic by incorporating into their Medigap products most of the benefits lost under Medicare. The liability for catastrophic coverage for the elderly is thus being transferred from the federal government back to the private sector. Now that the private sector is responsible for financing these benefits, most insurers will find it necessary, as the government did, to charge higher premiums.

The repeal of MCCA is not the only factor affecting Medigap premium levels. Medigap premiums are affected by the same cost and utilization trends that have been driving up Medicare spending itself. Between 1984 and 1989, Part B spending nearly doubled, and over the same period, the Medicare hospital deductible increased by 57 percent. A simplified illustration of the contributions made to Medigap cost increases by the repeal of MCCA and trends in health care costs and utilization are shown in Attachment A.

Another factor affecting rate increases is the adequacy of prior rates. Blue Cross and Blue Shield Medigap products are generally subject to stringent rate review. Regulators have often been reluctant to grant the Medigap rate increases necessary to keep pace with annual increases in the Medicare deductible and in the utilization of services by

beneficiaries. Indeed, a GAO study of Medigap loss ratios found a 1987 average loss ratio of 104 percent among the 6 Blue Cross and Blue Shield Plans that it surveyed. This means that these Plans paid out more in Medigap benefits than they collected in premiums. In such situations, the losses must be subsidized by other lines of business, potentially increasing the costs of health insurance to other groups and individuals. With this overview as background, I would like to address the effects of MCCA's repeal on Blue Cross and Blue Shield Medigap policies specifically. Blue Cross and Blue Shield Plan Medigap policies have traditionally provided our subscribers with substantial value and a broad range of benefits, which generally exceed significantly the minimum requirements of federal and state law. This tradition was upheld when the Medicare catastrophic coverage legislation was in effect and will continue now that the legislation has been repealed.

In 1987 and 1988, the average non-group Medicare supplemental policy offered by a Blue Cross and Blue Shield Plan paid out more than 90 cents in benefits for each premium dollar collected. Such returns substantially exceed the 60 percent loss ratio required of individual Medigap policies under the NAIC minimum standards.

In 1989, Blue Cross and Blue Shield Plan Medigap rate increases were quite moderate overall -- about 8 percent -- and a significant number of Plans were able to reduce their rates or hold them constant because of the savings attributable to MCCA.

Last fall, when Congressional and public interest in the impact of repeal on 1990 Medigap premiums sharpened, we developed both national estimates and survey data to respond to the need for better information. First, we developed estimates of the range of potential increases in Medigap premium costs attributable to repeal of the catastrophic benefit. Based on national average data, we estimated that the monthly benefit and administrative costs associated with filling in the new gaps in Medicare coverage would range from $3 to $8 per person for catastrophic hospitalization, and from $2 to $8 for the cost-sharing for skilled nursing care. We estimated that the repeal of the 1990 catastrophic cap on Part B cost-sharing would result in a loss of savings to private insurers estimated at $3 to $8, a savings that would have been reflected in lower premium increases in 1990 had the catastrophic legislation remained in effect. In total, then, the increase in projected Medigap costs resulting from the repeal of Medicare catastrophic coverage was estimated to be from $8 to $24 per month in 1990.

We followed up these national estimates with a survey of Plans in November. Responses from 38 Blue Cross and Blue Shield Plans regarding their most commonly sold non-group Medigap products indicated that the median expected increase in 1990 premiums was about 29 percent assuming the repeal of Medicare catastrophic benefits. Had the law remained in effect as enacted, the median premium increase would have been about 9 percent. These findings are illustrated in Attachment B.

Since the December 7 adoption by the NAIC of revised Medigap regulations, those 1990 rate increases that states have approved for Blue Cross and Blue Shield Plan Medigap policies are generally consistent with our earlier estimates.

Changes in Medigap Regulations

Medigap insurance is governed by standards developed by the NAIC and adopted by states. These standards, which establish minimum benefit and loss ratio requirements, are also incorporated in federal law. The standards are known as Baucus standards, after Senator Max Baucus (D-MT), the sponsor of the 1980 legislation establishing the voluntary federal certification program. Under the law, the federal voluntary certification program does not apply in states that adopt either the NAIC standards or more rigorous ones.

When MCCA passed in 1988, the Congress recognized that the standards for Medigap would have to be revised both to assure

that the minimum benefit requirements did not duplicate the new Medicare benefits and to establish procedures for making any necessary adjustments in Medigap premiums. Appropriately, the Congress looked to state regulators to make the needed modifications, and the NAIC acted promptly in 1988 to develop transition rules and revised model standards for Medigap. The states had one year in which to adopt these standards and most states adopted the revised model standards by the statutory deadline.

When, subsequently, the Medicare catastrophic benefit was repealed, modification of Medigap products was again necessary. Once more, the Congress directed the NAIC to develop transition rules and revised model standards, which would be incorporated by reference into federal law. The NAIC responded promptly. In an environment on the verge of chaos, the NAIC facilitated a smooth transition and should be commended for its swift and responsible action.

Under the minimum standards adopted by the NAIC on December 7, Medigap policies must cover: all or none of the Medicare hospital deductible ($592 in 1990); all Medicare coinsurance for days 61 through 90 of a hospitalization ($148 per day); all Medicare coinsurance for hospitalization during a person's 60 lifetime reserve days ($296 per day); 90 percent of hospital costs after exhaustion of the Medicare benefit, up to 365 additional days of hospital care; all Medicare Part B coinsurance for physician and other medical services after the $75 Part B deductible; and the costs of the first three pints of blood under both Part A and Part B of Medicare.

New NAIC transition rules required private insurers to notify their policyholders by the end of January of the changes in Medicare and the corresponding changes in their Medigap policies and premiums. In addition, consistent with the MCCA repeal legislation, the NAIC transition rules required that Medigap insurers offer to reinstate coverage for policyholders who dropped their coverage in 1989, on substantially the same terms it was offered in 1988 and without imposing any waiting periods for treatment of pre-existing conditions. This offer was required to be made by January 30, 1990.

The NAIC transition rules provide -- both for 1989 when the industry was adjusting to the enactment of MCCA, and for 1990 when it must adjust to repeal -- that premium changes must be reasonable and justified by the circumstances. Specifically, the NAIC rules provide that Medigap premium adjustments that are due to changes in Medicare benefits result in a loss ratio at least as high as that originally anticipated for the policy. The loss ratio measures how much of the premium goes to pay benefits under the policy: the higher the loss ratio, the greater the portion of the consumer's premium dollar that is returned as benefits. The intent of this NAIC rule is to ensure that insurers do not receive "windfalls" solely as a result of legislative changes in Medicare benefits.

In addition to addressing issues concerning Medigap benefits and rates, the NAIC in December approved new standards to protect consumers in the Medigap market. The NAIC model consumer protections include provisions to:

- regulate agent commissions on replacement policies;
- require insurers and agents to ask questions to identify duplicative coverage;
- prohibit the sale of a Medigap policy to a consumer who already has such a policy and intends to keep it; and
- require insurers to waive waiting periods for pre-existing conditions for any new Medigap policy that replaces another similar Medigap policy.

These provisions are contained in the NAIC minimum standards and, as such, have been incorporated by reference into the Medicare law.

Role of the Federal Government

As a result of the Medigap provisions adopted by the Congress in the Medicare catastrophic repeal legislation and action by the NAIC, states, and private insurers, beneficiaries can be assured that their Medigap policies will provide protection against the costs of extended hospitalization and Part B coinsurance liability. Provisions of federal and state law also help to protect consumers against unscrupulous sales practices and, as indicated previously, the NAIC recently adopted a comprehensive set of additional model provisions in this area.

In our view, most states did a good job of enforcing the original 1980 standards. In 1988, the Congress and the NAIC determined those standards needed strengthening, particularly in the area of compliance with minimum loss ratios. The mandatory reporting of loss ratio data by insurers and the analysis of those reports by insurance departments and the NAIC is on schedule. The Blue Cross and Blue Shield system is working closely with regulators and NAIC staff to ensure the accuracy of those data.

We believe that the Congress should continue to rely on the standards developed by the NAIC to ensure that consumers receive reasonable value and benefits in their Medigap coverage. We recognize, however, that some states are in a better position than others to devote resources to the rigorous enforcement of the wide range of Medigap regulations that have been developed. We are encouraged that in 1989 a number of departments received strong state gubernatorial and legislative financial support for this and other regulatory priorities. We believe that the federal government could play an important role in 1990 and beyond by encouraging the establishment and operation of effective state regulatory programs and supporting consumer education efforts, such as beneficiary counseling programs.

Should the subcommittee decide to proceed with changes to the federal law provisions affecting Medigap, we recommend that you consider strengthening the federal process for reviewing state regulatory programs. Specifically, states could be required to demonstrate that they have mechanisms in place for the review of Medigap loss ratios and that they take appropriate actions against policies that persistently fail to deliver reasonable value to consumers. Under this approach, the Secretary of Health and Human Services or the Supplemental Health Insurance Panel could be authorized to withdraw approval of the state's regulatory program if the program's effectiveness could not be verified. We believe that this proposal would strengthen federal and state efforts to protect seniors who purchase Medigap without supplanting state regulatory authorities.

We do not recommend that you amend the federal law penalties dealing with Medigap marketing abuses. We believe that the states should be given the opportunity to adopt the new NAIC consumer protection amendments and that, before changes in federal law are contemplated, the administrative feasibility of these amendments be tested through their actual implementation.

Finally, we have serious concerns about proposals to change the role of the federal government in this market to one of designing standardized benefit packages that insurers must offer to the elderly. Consumers have been well-served by worthwhile benefit innovations such as health promotion plans, dental coverage and eye care, and we believe that rigid control of the content of insurance policies would stifle, rather than enhance, market responses to changing consumer needs. Based on our experience in this market, beneficiaries will question why insurers have been required to drop benefits that beneficiaries considered valuable. We should also point out that standardized benefits could leave consumers with the mistaken impression that all Medigap insurance is alike, failing to reveal important differences among insurers in service, reliability and accessibility. Moreover, standardization would

impede the development of innovations that may contain Medigap costs, such as the use of preferred provider networks.

Consumer education, not federally-prescribed benefit packages, is the best approach to minimizing beneficiary confusion in this market, and the Blue Cross and Blue Shield Associationwould be pleased to work with this subcommittee toward this end. An approach that we proposed last year would require insurers to show consumers how a Medigap policy offered for sale compares with the minimum standards.

Conclusion

Most senior citizens who purchase private Medigap insurance to supplement their Medicare benefits will face increases in their premiums in 1990 due to the repeal of MCCA, rising health care costs and, in some cases, other factors. Their policies are being modified to assure that they will be protected against catastrophic acute-care expenses. We in the Blue Cross and Blue Shield organization are committed to providing our subscribers with the benefits that meet their needs, the service they deserve, and exceptional value for their premium dollar.

We do not believe that additional federal regulation of the Medigap market is necessary. We urge the Congress to continue its support of sound regulation of the Medigap market by states and to consider strengthening the criteria for federal approval of state regulatory programs.

We would also urge you to continue to examine ways of containing rapidly rising Medicare costs, particularly in Part B. We supported the initiatives taken by this subcommittee to reform physician payment under Medicare, and are hopeful that these reforms will help slow the growth in Part B spending over time. Reducing Part B spending growth will help restrain increases in the Medicare Part B premium and in private Medigap insurance premiums. In the short term, if the Congress wishes to provide some financial relief to beneficiaries facing Medigap premium increases, you may wish to consider reinstating some version of the health insurance premium tax deduction that was available to individuals prior to 1983.

2534S

Chairman STARK. Thank you.
Linda.

STATEMENT OF LINDA JENCKES, VICE PRESIDENT, FEDERAL AFFAIRS, HEALTH INSURANCE ASSOCIATION OF AMERICA

Ms. JENCKES. Thank you, Mr. Chairman.

If I may, I would like to submit my complete statement for the record and highlight it briefly.

Chairman STARK. Without objection.

Ms. JENCKES. Thank you.

The HIAA is proud of its record in helping Medicare beneficiaries ensure for the financial liabilities left uncovered by the Medicare program. Some 22 million seniors, over 70 percent of the Medicare population, have private insurance to supplement Medicare.

Based on a recent survey, we are pleased to note that 90 percent of the market is satisfied with the benefits, and 75 percent are satisfied with the cost. Effective cost containment by Medicare which could help hold down the 14 to 16 percent annual increase in part B costs would go a long way in making these policies even more affordable.

The recently passed physician payment reforms, which this subcommittee helped pioneer, should help. We want to work with you to see what other avenues should be explored.

We feel that supplemental policies are an excellent value for most senior citizens in helping fill the gaps in the Medicare program so that individuals can have truly comprehensive or catastrophic coverage if they choose. As Medicare changes, so too have our products. The transition to the catastrophic law and its subsequent repeal all went smoothly with minimum disruption for the elderly.

We want to assure that the public can continue to rely on this private, supplemental protection, make the best decision on which policies to purchase, and be assured that the price is reasonable and the way it is sold is fair and ethical. What I would like to do is briefly discuss some of the concerns that have been raised by you and other Members of Congress.

No. 1, on the subject of confusion, as several other witnesses indicated before, and as we all well know, the Medicare program itself is very complicated. The basic deductibles and copays may be understood, but the basis on which benefits will be paid can be very complex. We pay by Medicare's rules and try to make it as simple as possible to understand. To lessen the uncertainty, all Medicare beneficiaries receive a Government-written buyer's guide which contains advice on Medicare supplements and shopping for coverage.

An outline of coverage must also be provided before a sale is made. It outlines very simply what Medicare pays and does not pay and what the supplemental policy will pay.

There are minimum standards for all such policies. New regulations by the NAIC just approved in December now require that additional benefits beyond the minimum standards must be separately indicated in the outline of coverage. I would like to offer copies

of the guide and the outline of coverage for your review as well as the survey that I mentioned earlier.

We also support recently introduced legislation which would provide for counseling and assistance and establish toll-free hotlines. In addition, it has been suggested that policies be standardized so as to allow only a few benefit options beyond the minimum requirements. We do not support standardization at this time, but suggest looking at the effectiveness of this approach in those States which currently require it.

It is my understanding that in the States that have it, there have been several revisions to the standardization requirements, all intended to improve, if you will, the initiative. I think it is very important to look at why the changes were made.

Also, we are presently surveying our companies to determine exactly how much variation actually exists. We will be happy to share the results with you. I suggest that since the outline of coverage now requires the listing of additional benefits, it should help consumers comparison shop as well.

The second area of concern is consumer protection. I have attached to my statement a very brief list of the Medicare supplement consumer protections which may be easier to follow. I do not think there is any other product that offers as many consumer safeguards to the public. There is a mandatory disclosure of key facts; minimum benefits, as I mentioned before; approval of advertising, and many others.

In addition, there is the unfair trade practices law in every State which prohibits using false information or advertising, rebates, unfair discrimination, unfair claims settlement, or unfair methods of competition. There are also agent licensing laws which allow States to issue fines, revoke licenses, and publicize disciplinary action.

Last week the Senate Aging Committee held a hearing and had as a witness a former agent who is in prison for having been abusive in selling policies to senior citizens. We feel that he is right where he belongs, and where others belong if they do not sell the product in an ethical fashion.

The NAIC in response to continuing concerns recently added even more consumer protection provisions at their December meeting. Duplicate policies in effect are banned. Cold lead advertising, twisting, and other abuses that were mentioned earlier are prohibited. Agent commissions are restricted. Preexisting condition clauses are restricted. All policies are noncancellable. And there is now regulation of actual instead of predicted loss ratios. Policyholders must disclose their past and present health insurance.

These laws already exist in the States, Mr. Chairman. We want to see them enforced, as you do. And we would like to see them have a chance to work.

Another suggestion has been made to increase the civil penalties for violations of prohibited practices from $5,000 to $25,000. While we would support the increase in fines, we feel that existing penalties are probably adequate. What is needed, again, is to enforce what exists and also expose however few or many bad agents there are.

The final point, on loss ratios, is that there are adequate loss ratio standards for Medicare supplemental policies. Again, we want them enforced. If a company has not met the standard, there should be a reduction in premium as required by State law.

We feel that the present loss ratio standards are adequate, given the different ways in which a product is marketed. In recent testimony, the NAIC has indicated that approximately 95 percent of the total Medicare supplement premium is being paid to insurers that meet the loss ratio standards. We would like to see the other 5 percent in premium income also toe the mark.

Mr. Chairman, we agree with Blue Cross and Blue Shield on the preemption of State laws. We again want the existing State regulations enforced.

The other comment I would like to make in closing is that in terms of indemnity policies, we would like to say that, yes, they are legal. In fact, there are many protections in place for these policies too, including minimum requirements. We stand firmly behind the States endorsing and enforcing these requirements.

Mr. Chairman, again, we feel the market is responding well to the needs of Medicare beneficiaries. Whatever problems may exist we want corrected. We want the beneficiary to be better informed because it will help the entire system. We are confident that seniors who purchase or maintain policies find good value in the policies and in the service provided by both companies and agents.

Thank you. And I would be happy to respond to any questions you might have.

[The statement of Ms. Jenckes follows:]

STATEMENT OF LINDA JENCKES, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. Chairman and Members of the subcommittee, I am Linda Jenckes, Vice President for Federal Affairs of the Health Insurance Association of America. The HIAA is the principal trade association of the commercial health insurance industry. The 330 HIAA member companies underwrite over 85 percent of the private health insurance available from commercial companies in this country. Sixty HIAA member companies underwrite Medicare supplement policies.

I am here today in response to your request for our comments on the Medicare supplement insurance market, and will address such issues as compliance with loss ratio standards, the sale of duplicate policies, confusion among consumers and marketing abuses.

Medicare provides our senior citizens invaluable basic protection against health care expenses, yet three quarters of the program's beneficiaries also have private health insurance to protect themselves against expenses not covered by Medicare. A 1989 survey by the HIAA revealed that about a third of those seniors with private coverage in addition to Medicare have it provided by a former employer. Of those persons with private coverage not obtained through former employment, 45.1 percent purchased it through a group or association, 44.5 percent from an insurance company or agent, 6.9 percent by mail and 3.5 percent belong to a health maintenance organization.

Regulation of Medicare Supplement Insurance

It is important to note that Medicare is an extremely complicated benefit program - one whose details have been modified over the years by Congress. Beneficiaries may understand basic facts such as the amount of the current Part A hospital deductible ($592) or the fact that the program pays only 80 percent of Medicare-approved physician charges, leaving the beneficiary to cover the other 20 percent plus whatever additional amount above the approved level the physician may charge in nonassigned claims. But the circumstances under which various types of health services will or will not be covered by Medicare can be complex. Because most Medicare supplement benefits dovetail with those provided under Medicare itself, they reflect that complexity.

Nevertheless, a great deal has already been done to help seniors understand both Medicare and Medicare supplement insurance. Whenever a person eligible for Medicare applies to purchase any type of health insurance they must be given a government written "Guide to Health Insurance for People with Medicare" which contains a good basic discussion of Medicare, Medicare supplements and other types of private health insurance, and gives sound advice on shopping for coverage. Also, at the time application for a Medicare supplement policy is made, the applicant must be given an outline of coverage in a format prescribed by the government that shows 1) what Medicare pays and does not pay, and 2) which of the supplemental benefits provided by the policy are required under the minimum standards for such policies and which of those benefits are additional to the minimum requirements. Further, whenever Medicare changes its benefits, insurers are required to notify their supplement policyholders 30 days before those changes take effect, describing the changes in Medicare and any changes in their supplement coverage that will result from them.

Mr. Chairman, at this point, I would like to offer a copy of the current buyers guide and the model outline of coverage for insertion in the hearing record. I would like to emphasize, also, that this information is provided to all applicants before a policy is issued to them and that each applicant has a 30 day "free look" period following issuance within which to cancel the coverage at no cost to themselves.

New Consumer Protection Provisions: The states are currently in the process of implementing revisions to their Medicare supplement regulations. Under these important new consumer protection provisions:

- Individuals purchasing Medicare supplement insurance policies cannot be cancelled for any reason except for failure to pay the premiums or a material misrepresentation.

- People obtaining coverage under group Medicare supplement insurance policies are no longer subject to loss of coverage if their membership in that group ceases or the group policy itself terminates. They will be offered continuation of coverage through an individual policy.

- Duplication of Medicare supplement policies is banned.

- Insurance companies and agents, when soliciting applications for Medicare supplement insurance policies, are required to obtain additional information concerning applicants' past and present health insurance coverage. This information will ensure that individuals do not own more than one Medicare supplement policy.

- In order to assure that sales of duplicative Medicare supplement policies do not occur, insurance companies are also required, annually, to review their records for persons who have more than one Medicare supplement policy and report their findings to the states.

- While replacement of existing Medicare supplement insurance coverage with a new policy of that type will still be a choice allowed consumers, existing state regulations which already require extensive disclosure of the results of replacement are supplemented by new requirements which:

  -- Prohibit the new insurer from imposing any new preexisting condition limitations or waiting periods for benefits being replaced, and

  -- Place limits on compensation of agents in order to lessen their incentive to replace existing adequate policies.

  - If they have not already done so, insurers are required to establish written marketing procedures to assure regulators that both existing and new consumer protection requirements are complied with.

- Such practices as twisting, cold lead advertising, and high pressure tactics are prohibited as part of the sale of Medicare supplement insurance policies.

Importantly, these new consumer protection provisions are in addition to existing state regulations which

- prescribe the minimum benefits that a Medicare supplement must provide,

- require that policies automatically adjust to changes in Medicare deductibles and copayments,

- specify the information that must be provided by an insurer or agent when a policy is sold or updated,

- prohibit certain types of policy limitations or exclusions, and

- require insurers to meet loss-ratio standards involving the ratio of claim payments to premiums.

In addition to its broad authority to regulate insurance, virtually every state has in effect the "Unfair Method of

Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance" statute. While the text of the Unfair Trade Practices Act is lengthy, it addresses virtually every aspect of company and agent activity and prohibits practices such as providing false information or advertising, rebates, unfair discrimination, unfair claim settlement practices and other unfair methods of competition or deceptive acts or practices. Insurance departments have other sanction authority such as their agent licensing laws which also enable the state to issue fines, revoke licenses and publicize the results of disciplinary actions.

We can well understand that in the wake of the repeal of the Medicare Catastrophic Health Insurance Act, the Congress is especially interested in Medicare supplement insurance and is considering legislation aimed at correcting marketing abuses and assuring that seniors receive fair value for their insurance dollars. However, we believe that the consumer protection provisions, now being put into place by the states, are more than adequate in most respects and suggest that, before it acts to impose further changes, Congress generally should wait until it can evaluate the effects that the new NAIC provisions have on the marketplace.

LEGISLATIVE PROPOSALS

Proposals currently before the Congress would employ a variety of approaches to deal with perceived problems in the Medicare supplement marketplace. We offer the following comments on them.

Counseling Medicare Beneficiaries: Having sounded a cautionary note, we would like to state our support for immediate federal legislation to promote proposed health insurance counseling and assistance as proposed recently by Senator David Pryor. We believe that many seniors would benefit from either group or one-on-one counseling concerning Medicare, Medicare supplement insurance, long-term care insurance, Medicaid and other forms of health coverage as provided for in this proposal. The dissemination of written material on these topics can only accomplish so much. We have no doubt that unbiased personal assistance would be a great help to Medicare beneficiaries seeking to purchase health coverage that is appropriate to their circumstances. Programs of this type already in existence have earned a high degree of consumer support and their value has been recognized by a recent resolution of the National Association of Insurance Commissioners encouraging all states to develop them.

We also believe that the outreach called for by Senator Pryor's proposal is very important, as many of the seniors needing insurance counseling live in isolated, often rural, circumstances. Outreach is also important in reaching persons on Medicaid who do not need to purchase a Medicare supplement or keep one they might already have purchased, because Medicaid will pay the Medicare deductibles and copayments.

Similarly, the establishment of toll-free hotlines in each state to assist callers with Medicare supplement questions or problems, as called for in a bill introduced by Senator Herbert Kohl, would be a worthwhile and cost-effective initiative.

Increased Civil Penalties: We would support increasing the federal civil penalties for violations of the prohibited practices set forth in Section 1882(d) of the Social Security Act. Increasing the penalty from $5,000 to $25,000 for each infraction would indicate how seriously the Congress views such abuses. But, we believe that penalties, in and of themselves, are not a particularly effective deterrent. It is the certainty of being caught and punished, rather than the severity of punishment that may be imposed, that deters people from engaging in prohibited activities. Thus, we suggest that the more important question for consideration by the Congress is how actively and effectively existing federal and state laws are

being enforced rather than whether the existing penalties are adequate.

We believe that both the federal and state governments already possess adequate powers to deal with the relatively few abuses that occur. Agents and companies who commit abuses in marketing health insurance to Medicare beneficiaries should be disciplined and the news media should be asked to cooperate in letting the public know who the bad actors are. The light of adverse publicity focused on the few who are misbehaving is the best way to achieve improvement. Increasing efforts under existing law to expose and embarrass the bad actors will accomplish far more than additional regulations inadequately enforced.

Approval of Premium Rates: It has also been proposed that all states be required to specifically approve any premium increases for Medicare supplement insurance. Virtually all states presently have such a requirement for individual policies, but many do not require approval of group premium rates. We suggest that before Congress imposes such an approval requirement on states that have not chosen to regulate group premiums it should first find out whether there are any meaningful differences in the cost of Medicare supplement insurance between states that have such regulation and those that do not.

Standard Medicare Supplement Policies: One often-heard criticism is that under current law - which requires that Medicare supplements provide certain minimum benefits, but does not limit the additional benefits a policy can provide - consumers are faced with too much variation among policies to make sound price comparisons. Therefore, it has been suggested that the federal government act to require standardization of policies.

Several states have implemented standardization schemes which allow for some variation in the content of Medicare supplement policies, but allow insurers to offer only specific variations. These state standardization requirements are relatively new and vary in detail. They should be closely monitored in order to determine whether their demonstrated merits are sufficient to justify incorporating standardization into the NAIC regulatory model for all states to adopt.

The HIAA is surveying our largest writers of Medicare supplement insurance to determine the degree of meaningful variation that currently exists among policies and how much current coverages might be affected by the standardization concept.

At this point, lacking conclusive evidence of the value of standardization compared to the loss of consumer choice it would entail, we are not prepared to support the concept.

Ban Sale of Indemnity or Dread Disease Policies: We do not agree with proposals to effectively prohibit the sale of indemnity policies to Medicare beneficiaries. Such policies pay a stated cash benefit upon hospitalization. For example, $100 for each day a person is hospitalized. A "dread disease policy" would pay, for example, various cash benefits based upon the type of cancer treatment. Such policies are certainly no substitute for a Medicare supplement policy, but for a person who has a Medicare supplement, they can provide useful supplemental income in case of serious illness.

One of our member companies did a study of indemnity policy owners which showed:

- 75 percent use the indemnity payment received to cover expenses related to their illness not covered by other insurance;

- o 50 percent used it to pay for post-hospital expenses such as home health care, ambulance service or prescription drugs not covered by Medicare;
- o 23 percent used it to pay for extra costs in the hospital such as having a private room or a t.v.;
- o 17 percent used it for transportation and parking costs for family members visiting the hospital; and
- o 13 percent used the payment to replace lost earnings.

Protection for such expenses, while not as essential as the coverages provided by Medicare supplement policies, is still useful to have and should not be denied the elderly. We certainly do not believe that anyone should purchase the number of indemnity policies that are cited in the examples of outrageous insurance sales abuse cited by some reform advocates. But we do believe that consumer education, as embodied in proposals for counseling programs and consumer hotlines, is the best way to counteract such abuse - both in preventing future multiple sales and in persuading current owners of multiple policies to drop excessive coverage.

Importantly, unless the government deprives people of their existing insurance when they reach age 65, banning the sale of these coverages to persons over 65 would only cause more of them to purchase it under that age, so they would have the coverage after they reach 65.

Again, the best course is to educate and inform consumers about the relative value of these coverages and let them make their own purchase decisions.

Raise Minimum Loss Ratios: The current loss ratio standard for Medicare supplement insurance is 75 percent for group policies and 60 or 65 percent (depending on the state) for individual policies.

The General Accounting Office has reported that many insurers are not meeting the minimum standards. We note that the GAO methodology is different from the way loss ratios are analyzed by the states and, therefore, there is considerable confusion on this subject. The position of the HIAA is that insurers should be meeting the loss-ratio standards as defined by the states and that regulators should require premium reductions where appropriate to assure that insurers do meet the standard.

We believe that the revised NAIC loss ratio reporting requirements will enhance enforcement of loss ratio requirements.

We do not agree, however, that the current standards should be raised.

The fact that AARP and some Blue Cross/Blue Shield plans have higher loss ratios is not indicative of the insurance industry's overall ability to return a higher loss ratio particularly on agent-marketed business. For example, much of the AARP business may no longer involve any marketing expense in the premium calculations because it was sold by the AARP's first insurer and then transferred to its second insurer who incurred no marketing expense on the transferred business. Further, new sales are made on a direct mail basis to AARP members and the quality of this membership organization is such that the response level to these mailings is high enough to minimize marketing expenses. Many Blue Cross/Blue Shield organizations do very little active marketing of Medicare supplement coverage and thus they, too, have very low marketing costs for this type of insurance.

Further, a high loss ratio is not necessarily indicative of a policy being a "good value" to the consumer. A policy with a high loss ratio can have a higher premium than the same coverage

with another insurer with a lower loss ratio. The price for a given amount of coverage, not its loss ratio, is the important criteria for the consumer.

Insurers market their polices in a variety of ways, through association groups, by mail, and through insurance agents. Because the cost of marketing and servicing group policies is lower than for individual policies, the states require a higher loss ratio for group than for individual business. Where employer association groups are used, the sponsor often bears some cost of administration outside of the insurance program, and additional savings for groups are garnered through mass enrollment, limited group eligibility, and in some cases, nonprofit postage rates.

Raising the loss ratio standards for individual Medicare supplement policies will largely eliminate the use of agents in marketing this type of insurance. Before taking that step, the Congress should consider that it is agents who effectively reach individuals who are not reached by Blue Cross and Blue Shield plans (who tend to make coverage available but not actively market it) or organizations such as the AARP who market group coverage by mail to only their members.

Importantly, although a number of companies are not meeting the loss ratio standard, the NAIC has noted that 95 percent of the premiums paid for Medicare supplement policies are being paid to companies that are meeting the standard.

Replace State Regulation With Federal Regulation: Some critics of the efficacy of the existing pattern of state regulation of insurance would have the federal government directly regulate the Medicare supplement industry. We certainly would not recommend such a course of action.

Examples abound of inadequate federal oversight and regulation in areas of the economy where it has exercised direct regulatory power. There is no real evidence that the federalization of all or part of the regulation of Medicare supplement insurance would improve the situation. Given the lack of federal expertise in insurance matters and the chronic shortage of funds for existing federal activities, we believe that state government is the most appropriate site for regulation of Medicare supplement insurance. The federal government can be more effective as an overseer, critic and setter of guidelines for state regulation than as a direct regulator of insurance.

Ban Medical Underwriting of Medicare Supplement Policies: If everyone purchased health insurance when they first became eligible and never dropped that coverage, restrictions such as medical underwriting, preexisting condition limitations and waiting periods for benefits would be unnecessary.

Under current state laws, there is no waiting period for Medicare supplement benefits to become effective, other than a 6 month limitation on benefits for preexisting conditions. Under the new NAIC consumer protection provision, even 6-month preexisting condition limitations will be prohibited when replacement Medicare supplement policies are sold. The only way an insurer can protect against people who wait until they are sick to buy insurance is through medical underwriting, a practice which may deny coverage to some individuals whose present ill health makes them such poor risks as to be uninsurable. But, without medical underwriting, people could buy Medicare supplement coverage when they are sick and drop it when they are healthy - a prescription for the self destruction of any health insurance mechanism.

Creating access to coverage for medically uninsurable individuals is a public policy issue that extends to the entire population. Forcing insurers to accept all risks simply will not work. Special subsidized pools may need to be developed for people who cannot obtain coverage in the Medicare supplement

market. We would be happy to work with the Congress on devising workable ways to distribute the cost of covering the medically uninsurable across the health insurance market on an equitable basis.

Health Insurance Sales to Medicaid Beneficiaries: A recent survey commissioned by the American Association of Retired Persons found that, of the Medicare beneficiaries surveyed who also had Medicaid coverage, 51 percent had, in addition, purchased private coverage. We find that difficult to accept, since Medicaid programs generally pay the Medicare deductibles and copayments for such people. We suspect that since the survey was done by telephone, respondents may have become confused about the distinction between Medicare and Medicaid and between different types of private insurance.

Nevertheless, we believe that a few such individuals who are on the margin of eligibility for Medicaid may legitimately purchase indemnity policies (not Medicare supplement policies) because they feel unsure about their Medicaid status and the insurance expense counts toward the "spend down" requirement for eligibility.

We do not condone the sale of unneeded health insurance to people on Medicaid. However, more needs to be known about this phenomenon before the Congress decides what, if anything, should be done about it.

MEDICARE SUPPLEMENT PREMIUMS

It is important to look at the magnitude of premium increases being proposed by Medicare supplement insurers before examining the specific elements that led to premium increases. In a January 8 statement before the Senate Special Committee on Aging, the General Accounting Office reported on a premium increase survey it had just done of 20 of the largest Medicare supplement insurers. The GAO found that the average 1990 increase was 19.5 percent. The GAO also reported that, generally, the companies attribute about half of the increase to the repeal of catastrophic, which resulted in certain minimum benefits being added back into policies, and the other half to other factors such as rising health care costs, utilization trends and operating costs.

Based upon the limited information we have about current premium increases, we believe the GAO survey presents a fair picture of what is occurring. It agrees with our prediction - made to the House Committee on Aging prior to repeal of catastrophic - that average increases would be in the range of 20 to 25 percent.

An explanation of the specific factors which led to premium increases follows.

Repeal of the Medicare Catastrophic Coverage Act: Due to the repeal of Catastrophic, in 1990 all Medicare supplement policies, in addition to the other benefits they provide, must now cover the following expenses that they would not have covered had Catastrophic remained in effect. Specifically:

Part A (Hospital Services)

- $592 inpatient hospital deductible - the minimum benefit standard requires that Medicare supplements must either cover this entire amount or not cover it at all;
- $148 a day for the 61st-90th inpatient hospital days per benefit period;
- $296 a day for the 91st-150th inpatient hospital days (if the insured chooses to use nonrenewable Medicare lifetime reserve days);

- o upon exhaustion of all Medicare hospital inpatient coverage, including lifetime reserve days, coverage of at least 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare up to a lifetime maximum benefit of an additional 365 days.

Part B (Physician Services)

- o coverage of all coinsurance amounts (20 percent of Medicare approved charges) under Part B, regardless of hospital confinement, subject only to an annual deductible. (Had the catastrophic law remained in effect, the liability of beneficiaries and their Medicare supplement policies for copayments would have been limited to $1,370 in 1990.)

In addition to these benefit changes, the repeal also generated significant administrative costs for insurers because of the need to revise policies, file them for approval by state regulators and notify policyholders.

Many Medicare supplements provide broader coverage than the minimum required benefits. Optional benefits include out-of-hospital drugs, skilled nursing facility copayments, nursing home care not qualifying under Medicare, medical care outside of the U.S., and physician charges in excess of Medicare approved charge levels (balance billing). The costs of these optional benefits are also increasing. While the catastrophic program may have offset some of the cost of these benefits last year, their effect on premium must now be recalculated due to the repeal of the Catastrophic Act.

The Effect of Increasing Medical Costs on Medicare and Medicare Supplement Premiums: The majority of claims dollars paid out by Medicare supplemental insurers are for the 20 percent of Medicare-approved Part B charges which are the beneficiaries' responsibility to pay.

Due to rising physician fees, more services being provided the elderly, the higher cost of new technology and the fact many procedures which used to be done in hospitals are now done in doctors offices, Medicare Part B payments have grown from $13 billion in 1983 to $37 billion in 1989 - a compounded rate of 16 percent a year. It is estimated that the rate of increase will continue in 1990, resulting in payments by Medicare of about $43 billion for seniors covered under Part B.

Because Medicare supplement policies cover the beneficiaries 20 percent copayment, we are experiencing similar increases in supplemental claims payments.

The cost per claim is not the only problem, the number of claims is also rising. We believe that the increasing volume of Part B claims received by Medicare and supplement insurers is due in part to the "debundling" of services by providers. Debundling, or increasing the volume of covered services per beneficiary, is one strategy some providers use to counter recent federal restrictions and cutbacks in provider payments.

We also note that incentives built into the Medicare prospective payment system, by encouraging a shift away from inpatient hospital treatment to outpatient procedures, have had the effect of increasing beneficiaries and supplemental insurers costs. Because outpatient procedures are covered primarily by Part B, at 80 percent of Medicare's allowable fee versus 100 percent when done on hospitalized patients, this means that Medicare supplement policies must reimburse 20 percent of an increasing number of outpatient claims.

While many factors have caused claims costs to increase, cost increases for Medicare supplemental policies closely

parallel increasing Part B costs to Medicare. We believe that only nationwide solutions can effectively cope with rising expenditures for physician services. We hope that the Medicare Physician Payment Reforms enacted as part of the Omnibus Budget Reconciliation Act of 1989 will prove to be a major step toward a solution for Medicare supplements.

Other Cost Factors: In considering 1990 premium increases, it is important also to understand that the underlying health care costs of the people insured by each company differ. Insurers must project future health care costs and the utilization of benefits by their policyholders into their premiums. Variables that must be considered include:

- o the specific benefits provided in a policy;
- o the age of the policyholders (there is a direct relationship between age and utilization of health care);
- o the past claims experience for that policy;
- o regional variations in health care costs which may affect a company's insured population; and
- o a company's operating costs, including the way in which it markets it policies (i.e., through direct mail, agents, association or employer groups).

These variables can result in considerable differences in the premium charged. They are one reason why the GAO survey that I mentioned earlier showed that, of the 19 companies who are increasing their premiums, the amounts ranged from 5 to 51 percent.

Mr. Chairman, we are pleased to have had the opportunity to appear before your subcommittee today. We know that you recognize the value of Medicare supplement insurance in helping the elderly meet the substantial health care expenses that Medicare does not reimburse. We share your interest in seeing that supplemental policies continue to offer fairly priced, ethically marketed protection, and that our policyholders are satisfied with their coverage. In that regard, the HIAA survey that I mentioned at the beginning of this statement showed that nearly 90 percent of respondents reported satisfaction with policy benefits and 75 percent were satisfied with the cost of coverage.

If you have questions, I will be glad to respond now or, where it might be necessary, submit information for the hearing record.

MEDICARE SUPPLEMENT INSURANCE

CURRENT STATE CONSUMER PROTECTION PROVISIONS

- Mandatory disclosure of key facts before policies are sold
- 30 day "Free Look"
- Mandatory minimum benefits
- Policies automatically adjust to Medicare changes
- Regulations of projected loss ratios
- Approval of advertising

NEW NIAC CONSUMER PROTECTION PROVISIONS

- Cold lead advertising, twisting & other abuses prohibited
- Regulation of actual loss ratios
- Beneficiaries may own only one Medicare supplement
- Agent commissions restricted
- Prexisting condition limitations restricted
- All policies noncancellable
- Applicants disclose past and present health insurance
- Written marketing procedures

- Group conversion to individual coverage

[THE SURVEY AND THE OUTLINE OF COVERAGE AND GUIDE REFERRED TO IN THIS STATEMENT ARE BEING RETAINED IN THE COMMITTEE FILES.]

Chairman STARK. How many agents are in jail across the land? We have got one. Have you got a second one for me?

Ms. JENCKES. Mr. Chairman, I do not have an exact number on that, but I think——

Chairman STARK. How about a bet? I will give you $1 for every one over 10 if you will give me $1 for every one less than 10. I will take your word for it, or the insurance commissioner's.

Ms. JENCKES. Either way, I do not think either of us financially can lose. But I do think that is a question more appropriately addressed to the NAIC. It is my understanding that——

Chairman STARK. I understand that. But you want strict enforcement. So here we go, we have Harvest Life and Guaranteed Trust Life and Federal Home Life and American Insurance of Texas and American Republic and Blue Cross and Blue Shield of Alaska, all have low loss ratios—30, 40, 40, 48, and 49. We know where they are. Somebody is not doing anything. We could put those guys in jail, which I would support.

Then in the groups below 70, we have got Harvest Life—again, these guys really lead the pack here. Blue Cross and Blue Shield of Wisconsin, and New Mexico Blue Cross. Blue Cross and Blue Shield of Wisconsin was at 48 percent. I do think that my good friend, Mr. Moody, is going to sit still and not want to put those guys in jail. Colonial Penn Franklin, 68. And the beat goes on.

You suggesting that they should not have that low a loss ratio, right?

Ms. JENCKES. Mr. Chairman, I wish——

Chairman STARK. Is that a yes or no? Should they be allowed to sell insurance over periods of time—these are all for 3 years or more. Should they be allowed to sell those policies?

Ms. JENCKES. No, Mr. Chairman.

Chairman STARK. OK. So we ought to do something about it, should we not?

Ms. JENCKES. We agree.

Chairman STARK. And the States have not done anything about it, right?

Ms. JENCKES. I think the States now have in place more opportunities——

Chairman STARK. But these guys are still around. They are still peddling this trash. What are we going to do to stop that?

Ms. JENCKES. I think one important change was just made in December. No. 1, the reporting requirements for loss ratios is now standardized. I think that is going to help to a very large degree, in addition to which companies must now provide actual loss ratios rather than predicted loss ratios. I do think that they have to be looked at over time.

Chairman STARK. They were, 3 years. How much time do you want, another 3 years to cheat the public?

Ms. JENCKES. I do not think that the NAIC requirements in reporting regulations were in place when that calculation was made. In addition to which, I do think that the GAO is doing a superb job of trying to report to Congress and actually, for that matter, to everyone in the industry where in the aggregate or in the average a company is.

But I would like to suggest, Mr. Chairman, that the way the States actually calculate loss ratios is on a particular book of business. So you can see what the loss ratio is on Congressman Stark's policy in terms of, you know, the class or the book of business that was sold in the same year. I do not agree with Ms. Shikles that it is as accurate to take the average figures for all the companies for a certain period of time. That is not, in fact, how State regulators look at and calculate loss ratios.

Chairman STARK. Well, would you suggest to me that if there are still approximately 20 or 30 percent of the companies at the end of this year doing it, that we should then enforce Federal standards? Is there a point at which you think Federal standards should supersede the States? Is there any point you can name?

Ms. JENCKES. I think if you can prove that the States are failing to act, then I think we should definitely look at some type of Federal recourse. But as of right now, again, I do not think all of the tools have been properly in place and agreed to by the insurance regulators themselves.

Chairman STARK. Yes. But we can agree here federally. Why should we wait for the States to agree?

Ms. JENCKES. I think right now you have got approximately 6,000 people in place in the States who are very well-trained, in addition to which the States are financed to take care of the problem. I think it is obvious that perhaps some of the regulatory tools did not exist to date to get a fair reading of loss ratios.

Chairman STARK. What about redundancy?

Ms. JENCKES. Duplication of policies? We are absolutely opposed to duplication of policies, and we truly expect that the language that was adopted by the NAIC in December will work. We have long advocated that Medicare beneficiaries only have one Medicare supplemental policy.

It was noted before—and I would like at least to reference it, based on our——

Chairman STARK. What are they going to do to enforce that? What is the language they put in at the beginning of the year that you say is going to solve this problem?

Ms. JENCKES. Well, No. 1, all companies and agents are required to ask the beneficiary whether or not he or she has other insurance, in addition to which they have——

Chairman STARK. Do you trust these agents to answer that truthfully?

Ms. JENCKES. I would certainly I hope that the beneficiary will answer it truthfully.

Chairman STARK. How many insurance agents have you ever met that you could trust?

Ms. JENCKES. Quite a few, hundreds.

But, Mr. Chairman, if I may just clarify one point in terms of duplication——

Chairman STARK. Well, wait a minute. Seriously, what are you going to do to determine redundancy?

Ms. JENCKES. I think we have got to rely on consumers——

Chairman STARK [continuing]. You are going to say to the agent, you must not sell redundant policies.

Ms. JENCKES. That is correct. They must—every single application, whether sold through the mail or by an agent, or offered by a company direct must contain the question "do you have other insurance?" It is then up to the individual to answer that question honestly, fairly.

At the end of every year, it is my understanding that the new regulations will require every company to submit a list to the insurance department of individuals who have duplicate coverage. And in fact, most of our companies right now——

Chairman STARK. Based on their asking the customer and the agent filling out the form, what would be wrong with each State requiring every policy be registered? Then they could just match up the information.

Ms. JENCKES. I think that is a possibility. I would like to look at it.

Chairman STARK. That is what we require in our bill. Is there anything wrong with that?

Ms. JENCKES. I would like to look at it and see if it would work.

Chairman STARK. Just finally, the Blues tend to do a much better job with this stuff than other companies, and Empire, for instance, one of the great socially concerned Blues of all time. But your are concerned, Alan, about enforcement. Now, you think the States can do a better job than the Federal Government?

Mr. SPIELMAN. Absolutely.

Chairman STARK. Do you think that they do a better job collecting income tax than the Internal Revenue Service?

Mr. SPIELMAN. I do not know.

Chairman STARK. OK. Did you watch this series, "Eyes on the Prize"? Did you see what a great job the States did in enforcing desegregation?

Mr. SPIELMAN. Mr. Chairman, I cannot comment on that. What I can comment on is some——

Chairman STARK. Give me an example, one example, where the States have done a better job in some kind of law enforcement than the Federal Government, just one that you know off hand.

Mr. SPIELMAN. I think the example is before us in terms of insurance and the States——

Chairman STARK. There is no Federal law. You cannot compare that.

Mr. SPIELMAN. Well, there is. There is a Federal certification process here. And the Federal certification process, as I pointed out in my testimony, has largely been a paper review. There is not a staff capacity in HHS with expertise in medigap insurance. It is one of a number of issues that staff need to address.

Chairman STARK. Tell me what it takes to have expertise in medigap insurance. How would you rate Lorne Greene and Danny Thomas? Would you say they are experts in medigap insurance?

Mr. SPIELMAN. No, they certainly are not.

Chairman STARK. Well, they are the ones who explain it to my mother.

Mr. SPIELMAN. We do not use them.

Chairman STARK. Do you think it really takes much to understand medigap insurance?

Mr. SPIELMAN. I think it does. The reason why we are here today is to talk about the confusion in the marketplace. Indeed, I think it takes quite a bit of expertise to understand this market. And one of the problems that we always face——

Chairman STARK. So you think there should be standardized policies. That would make it easier for the consumers, would it not?

Mr. SPIELMAN. Well, what I was going to say, Mr. Chairman, is one of the problems we face here, for example, in minimum standards is making the delicate tradeoff between the scope of benefits to be provided and the cost. We don't want to set minimum standards so high that the policies become unaffordable. It does involve some sophistication.

On the question of standardization, we differ on the means to achieve the objective of reducing confusion. We do not believe standardization is going to do it.

Chairman STARK. At what point do you think the Federal Government should step in?

Mr. SPIELMAN. Well, what I would do, Mr. Chairman, I would——

Chairman STARK. Not what you would do; at what point? How bad do you think things have to get before the Federal Government ought to step in?

Mr. SPIELMAN. I would use the techniques you have used in the past. In Medicare Catastrophic Act you gave States a year to adopt new medigap standards. Within a year, virtually all of them did adopt exactly what you asked them to.

Now, postrepeal you have asked the States to do additional tasks.

Chairman STARK. OK. Now, if the States do not do it, what should the Federal Government do?

Mr. SPIELMAN. Well, I believe you have to assess that when that time comes.

Chairman STARK. Wait a minute, wait, wait. If I tell the States, please do it in a year or I am going to do something, and I will not tell you what, are the States going to? To get the States to do this, do you not have to have a penalty if they do not do it?

Mr. SPIELMAN. But we have had 10 years of a situation in which theoretically there is no ax that falls on the State administrator's head——

Chairman STARK. They have not done anything, have they?

Mr. SPIELMAN. But they have.

Chairman STARK. What?

Mr. SPIELMAN. All of them have adopted——

Chairman STARK. We have got one agent in jail that we have been able to find.

Mr. SPIELMAN. Well, I believe you have to separate out the agent abuses from the policy standardization issue. The bulk of this market is in policies that meet the minimum standards. Forty-six States adopted the minimum benefits standards.

You are absolutely right on loss ratio compliance, and you are right with respect to some agent abuses.

Chairman STARK. Some. Twenty-four percent of the people who buy these medigap policies have duplicate coverage. That is not an abuse? That is fraud. That is awful. That is unconscionable. To me that is the most obscene consumer ripoff I have ever heard of.

Mr. SPIELMAN. I would agree.

Chairman STARK. OK. We have had it for 10 years and nothing has happened? How many more? Ten more years, and then we should do something?

Mr. SPIELMAN. The balance that regulators must strike here is to determine at what point do they take policies away from people who already have——

Chairman STARK. What is wrong with the Federal Government doing this? What are you scared of? What do you see? What would harm the seniors and your companies if the Federal Government did enforce it? What terrible thing would befall you?

Mr. SPIELMAN. With respect to standardization, Mr. Chairman——

Chairman STARK. No, no, enforcement, to going in and requiring registration. It is very easy to know if there is duplication. We will just require each person to be registered by Social Security number and policy number. We will pop that out of the computer with no problem and then we go after whomever is doing this. What is wrong with that?

Mr. SPIELMAN. Well, one of the things that is wrong with it is that not all cases of duplication are conscious fraudulent efforts by agents or insurers to sell multiple policies. Our companies will ask about other coverage. In fact, the AARP survey points out that two-thirds of every medigap purchase involves someone asking——

Chairman STARK. Just very quickly the minute it is registered, you flag it, and you give them 30 days to correct it, give them their money back or twist. It is no problem.

Mr. SPIELMAN. But, Mr. Chairman, there are cases where individuals knowingly purchase multiple policies and do not tell their insurers that they have multiple policies.

Chairman STARK. So this will stop that. At least then we will make it very difficult. So the default mechanism will be very high. If you have somebody who really wants to throw their money at insurance companies just because they love them, I guess in a free country they are perfectly able to do that.

Mr. SPIELMAN. It was not my understanding that the chairman's bill would involve the Federal Government taking away policies from seniors if they have multiple policies.

Chairman STARK. But it would give the agent the time to go back and you could make a default. The person would have to really certify that they were crazy and they were wasting their money and so certify. If the agent could still prevail, I suppose you would keep an eye on him to see that he was not doing this very often.

Mr. SPIELMAN. That is no more than what is included in the new NAIC consumer protection standards that the States are in the process of adopting——

Chairman STARK. But there is no way to identify them.

Mr. SPIELMAN. There is not going to be anybody to identify them if you require HHS to do it either.

Chairman STARK. Why not?

Mr. SPIELMAN. Where is the bureaucracy to identify these people?

Chairman STARK. It is in place. We have got a Social Security number and a registration number for every policy.

Mr. SPIELMAN. We will have to look at the registration proposal. It is not my understanding——

Chairman STARK. I want to tell you something. Try not reporting some of your income this year, will you. And then whoever has to come and testify next year when you are doing time at the Ivan Boesky tennis ranch for trying to cheat the IRS, will find out how quickly they can identify who is paying and who is not paying.

Mr. SPIELMAN. We will look at the registration proposal. But it was not my understanding that it worked as you suggested.

Chairman STARK. OK.

Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I think one of the things that makes this problem so difficult is that a lot of the policies are not sold face to face. The problem is not necessarily because an agent out there is doing this, at least in my experience. And I do not know if you have any figures as to what percentage are sold through the mail. I know lots of people who would check that blank, "no, I do not have this insurance". That is why they are buying it. But that does not mean they do not have it.

The elderly are a different population. They pose a different problem. And I guess what I sense as the difference between your position and mine is not whether or not I like or do not like agents or insurance companies, but that in fact your product and your marketing and the whole issue of creative policies are not needed or of value to a large portion of this group. So we need to consider having a base policy that is very simple, maybe even no riders allowed, and all of these policies with the same name. So any senior who gets that literature sees the same name and they know I have that. And for these medigap policies, we may even need to consider registering them, and see if they conform to Federal requirements, and have the premiums monitored by the State.

It would be nice to have it in such a way that you have more than one company providing this base policy, and maybe separate entirely the options issue. What I am concerned about is eliminating duplication, playing on the fears and the vulnerability of the elderly, which I do not say is necessarily done intentionally. I mean, I have seen the mailings my mother gets. They are mass; they are faceless. And it plays into the anxiety of millions of elderly as they think, "maybe this will help a little more, maybe this means a little more security".

So I think if you look at the market we are dealing with, the issue in my mind is not ripoff or not ripoff. The issue is the market we are dealing with, the variability of capabilities in these years, the enormous variation in experience with buying this kind of product and so on and so forth.

I think that the issues raised by this bill are very important. It almost cannot be addressed by the ordinary insurance marketing, servicing sector. I like the idea of very standard language, very, very standard language on very basic benefits. I was reading the Minnesota stuff, you know, hospital coverage, part B copayments, five things, no more. You do not get into this issue of understanding this, understanding that, at least you minimize it to the extent humanly possible.

But you cannot enforce this stuff. I mean, with the kind of army it would require to enforce every one of these individual sales situations, we could be out there fighting against drugs.

So I am looking for a different system. I want a different market structure. And I appreciate your fear that if the Feds override the States by saying "you will provide this minimum core" that we are subject to lobbying groups who say, "well, that is not quite a big enough minimum core, we want this minimum core too." I am very aware of that.

But I think for this population in this area we could probably justify and maintain only the minimum core and let you develop that market out there that would in addition provide counseling services and prescription drugs and so on. More and more of the States are providing low income prescription drugs, but I do not think we want to interfere with that market. But there is a minimum market out there that I think we ought to begin talking about, addressing differently, outside of the ordinary market economy on which our nation relies because it is a different world. Look at the number that are over 85, and look at the number of those that have never dealt in this market in their lives.

So I hope you will take a look at some aspects of the bill that you have alluded to that you have not looked at and look at it from this sort of construct: not are agents good people, but this is a different market that we are dealing with. And the issues that underlie this bill are really issues that are out there affecting peoples' lives.

If you would care to, please comment on that broad statement, otherwise I look forward to working with you on details in the future.

Ms. JENCKES. Well, we agree with you that several consumer initiatives need to be looked at again. In the area of standardization, we agree, the language should in fact be the same.

Our only question on the benefits is, No. 1, we want to find out to what extent, you know, variation does occur. And we should have our survey back from our companies shortly, which I indicated I would like to, share with the subcommittee at that time.

Beyond that, I think we do have to look at Wisconsin and Minnesota which have had the programs in effect for a while, see why they have made changes, before we go to that next step. But I agree, the language has got to be the same for all beneficiaries so they can best understand what to purchase. And we do think the outline of coverage is an excellent first start now that it is required that any benefits beyond the minimum standards must also be indicated so you will be able to line up three policies and do some benefit shopping as well as price comparison.

Mrs. JOHNSON. I do agree that the examination of how the standards were changed between the time they were first adopted and the current time is very important for us to know.

Did you have something?

Mr. SPIELMAN. I would certainly agree with your point on uniform language. I would also note that the minimum standards have been increased. Blue Cross and Blue Shield plans traditionally have provided more than these minimum standards. But as a result of the Medicare Catastrophic Act and its subsequent repeal, the package does have new requirements. For example, the maxi-

mum deductible for part B expenses has been reduced. There also is a requirement that the medigap policy must fill either all or none of the Medicare hospital deductible.

States do adopt those minimum standards. As these new standards are implemented, in many respects you will have out there a core package available to everybody.

The only other comment I would make is that two out of three Medicare beneficiaries that buy medigap coverage purchase it either from Blue Cross and Blue Shield or AARP. Our plans typically offer maybe two or three options at most. There are some that offer more. I do not know how many AARP has, but it is a small number.

As a practical matter, when the decisions get made, by and large people are selecting either us or the AARP. And that does——

Mrs. JOHNSON. Did you say two of three buy either Blue Cross or AARP?

Mr. SPIELMAN. Yes.

Mrs. JOHNSON. Thank you.

Mr. SPIELMAN. In effect these beneficiaries have sorted through the 500 or so alternative policies and have gone to us or AARP.

Mrs. JOHNSON. Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Welcome. And if I might, Mr. Spielman, let me focus on page 11 of your testimony—it very much relates to this issue of the Federal versus the State role—where you talk about standardization. And you say in the middle of the page that "based on our experience in this market, beneficiaries will question why insurers have been required to drop benefits that beneficiaries consider valuable."

Now, as I understand it, the standardization proposal is that there be a certain minimum with options thereafter. I do not understand why beneficiaries would question why benefits have been dropped if you are talking about a minimum package with options thereafter.

Mr. SPIELMAN. Mr. Levin, the options will be federally prescribed. So if you are offering now a benefit that is not in the prescribed set of options, you will not be able to offer it any more.

Mr. LEVIN. Does the Stark proposal limit the options that could be offered?

Mr. SPIELMAN. Yes.

Mr. LEVIN. To what?

Mr. SPIELMAN. Seven. Plus the HHS Secretary, after receiving an application from an insurer, consulting with an advisory body, and considering the balance between offering additional options versus confusion in the marketplace, could render a decision that would enable an insurer to offer something in addition to that.

Mr. LEVIN. All right. So there is the discretion to go beyond—this is an effort to have enough standardization so people can do some comparison shopping?

Mr. SPIELMAN. Yes. And we are concerned about the delay and redtape. While I believe the chairman's bill does hit the nail on the head on the need for flexibility to adopt innovative benefits, we are concerned that the process will be too laborious. We are concerned that insurers, which are closest to the beneficiaries, which have the

focus groups and the beneficiary advisory groups to determine what is needed will be hamstrung in their ability to offer new benefits and will not bother to do so. And we believe that is a concern to the senior citizens of the country.

Mr. LEVIN. You then go on to say that "standardized benefits could leave consumers with the mistaken impression that all medigap insurance is alike."

Now, where you have a system of a minimum package with options thereafter, how would that happen?

Mr. SPIELMAN. Well, Mr. Chairman, I could line up one of our policies with another policy and give you the standard core package. And maybe my price might be a little bit higher because I have an inner-city service center where people can walk in and file their claims. That increases my administrative costs and it increases my claims costs because I am teaching people how to file their claims with me.

I also may have automatic claims filing, which Blue Cross and Blue Shield plans have been using for years, long before the 5-year period that was mentioned in the previous panel. This means that the medigap insurance claim is handled automatically. The individual files one claim—they file with Medicare. We then have an arrangement with the Medicare carrier to transfer that claim over, and we pay it. It solves the beneficiary claims filing burden, but it also means that we face higher claims cost.

Some of those intangibles go to the heart of whether or not the individual is getting real value and service from their medigap policy.

Mr. LEVIN. Why can you not just sell that quality as part of the reason for people paying a slightly additional premium?

Mr. SPIELMAN. You can. But it is difficult. And it is difficult for people to understand those sorts of features. A number of our plans are targeting those areas, such as automatic claims filing, for marketing literature. But the reason why we are here today is the difficulty of understanding this marketplace. It is hard to do. And I believe a Federal law that essentially says that policy X from the Blues and policy X from somebody else is the same may in fact lead people to the wrong determination.

Mr. LEVIN. When you put it that way, you essentially seem to be saying leave it complex and confusing because if it is too clear, people may not put a premium on quality. You are saying if it is too clear, people will not be able to see beyond the math. That is what you are saying. And I think that is a pretty hard case to sell anywhere.

Mr. SPIELMAN. What I am saying is that standardized definitions and consumer counseling is probably the best hope of sorting through this problem. Additional standardization of language would help. We already have out a minimum package, minimum standards that qualified medigap policies must meet. So some of that has been taken care of.

All I am saying is that the assumption or the signal that says that price is the only thing that needs to be focused on is not necessarily correct. And indeed, we took issue with the Consumer Reports article on that same point in that they did not consider service, they did not consider even the loss ratios in making their rec-

ommendations, and simply looked at price. While they did look at benefit design and other things to some extent, what is required is a more involved comparison.

I am not suggesting and I am not advocating more complexity—quite the contrary.

Mr. LEVIN. One last question. We were talking about duplication. Do you have any idea what percentage of Blue Cross and Blue Shield policyholders have duplicate policies?

Mr. SPIELMAN. No, I do not. We have never surveyed that. I have seen surveys by the HIAA and by the AARP that I believe range from 15 percent to 24 percent. I do not know that there is any difference in our experiences. I can say that we do not consciously sell people policies if they tell us they have other policies. But indeed in many cases, people do not tell us. And there is no way of finding out.

Mr. LEVIN. Do you ask them in each case?

Mr. SPIELMAN. The new requirements will require everybody to ask in each case. I cannot say definitively whether we ask in each case now. But I know a number of plans have very rigorous programs to get at this point, involving beneficiary counseling and questions over the phone. So I do not know that we ask in every case—I am sure we do not ask in every case—but in many cases we do.

Ms. JENCKES. Mr. Levin, based on our own survey, 85 percent had only one Medicare supplemental policy, 15 percent had two or more, but that is not of a medical supplemental policy necessarily. They could have an indemnity policy, hospital indemnity or dread disease, or income replacement policy.

Mr. SPIELMAN. And let me just add: we were quite supportive of the regulation that the NAIC developed which requires everybody to ask these questions. I believe it is a legitimate——

Mr. LEVIN. Let me just ask you though: Blue Cross and Blue Shield, why did you not take the lead? This really gets down to at least part of the heart of the issue. If a substantial number—that is 10, 15 percent of your policyholders—have two policies or more, why do you not take the lead?

Mr. SPIELMAN. Take the lead in what respect?

Mr. LEVIN. In trying to end that abuse, where it is an abuse.

Mr. SPIELMAN. I believe we have taken the lead. Last year, we sent up a proposal that would try to address the duplication of medigap policies by requiring a rigorous comparison of the existing standards against what is being sold. We have been supportive working with the NAIC on these model standards. A number of our plans have worked with beneficiary advisory groups, and other beneficiary groups in the senior citizens community to try to communicate the message, that holding more than one medigap policy is a waste of money. We have done a lot in that regard.

The question before us today is whether or not we should continue to rely on the States to regulate this market, or whether or not we should scrap that, and have the Federal Government regulate it all. My position is simply this. We have established new model rules for the States to adopt that would solve the problem. Let's give them the 1 year that you have already given them, in Medicare catastrophic repeal, to see if they adopt these rules.

Mr. LEVIN. OK. Getting back to the question Mr. Stark asked of you; if, after 1 year, it hasn't worked very well, then you would support a greater Federal role?

Mr. SPIELMAN. Yes.

Mr. LEVIN. Unequivocally?

Mr. SPIELMAN. It depends on the specifics of the provisions, but I believe if you saw a situation in which the majority of States did not take action to adopt the new NAIC minimum standards, I believe, indeed, we would be back here working with you on how to strengthen the Federal criminal and civil penalties to get at marketing abuses.

Chairman STARK. I want to thank the panel. I do want to point out, in fairness, that probably less then 10 percent of the policies issued are below the loss ratio standards, and so 90 percent of the policies have a pretty good record. The problem is that about a third of the companies are the ones who sell that 10 percent of policies that don't meet the standard. Having never met an honest insurance agent, I don't know how many agents really do the job, but it is, as I said in my opening remarks, a few bad apples that are lousing up the barrel. I want to thank the panel very much.

Our final panel is comprised of Carole Olson, special assistant to the executive vice president of the National Association of Insurance Commissioners; and we are also happy to welcome Thomas Borman, the commissioner of commerce, from the State of Minnesota. We welcome you to the committee, and ask you to proceed to keep the Federal Government out of insurance regulation in any way you see fit.

Ms. Olson, would you like to start off?

STATEMENT OF CAROLE J. OLSON, SPECIAL ASSISTANT TO THE EXECUTIVE VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, KANSAS CITY, MO.

Ms. OLSON. Thank you, Mr. Chairman. The NAIC represents the insurance commissioners across the country, as you know. Commissioner Earl Pomeroy, the president of the NAIC, regrets that he was unable to be here today.

Mr. Chairman, the NAIC believes that you and other members have played a constructive role in the Medicare supplement area by confirming the existence of the same abuses as regulators in this marketplace. The NAIC is concerned about companies that rip off the Nation's elderly, and it does not defend States that fail to take action against companies.

Consumers were confused after the enactment of the Catastrophic Act, itself, and are even more confused after repeal. The States are moving quickly to revise their standards and educate the seniors. I would like to respond to a few statements that were made earlier in the day.

In answer to a question that was raised, and not meant to defend any abuses by any means, but the total percentage of gross premium dollars does meet the loss ratio standards.

The second point that I wanted to make is that a statement was made that a State cannot do anything about low loss ratios of companies whose master policies are located outside the State. That is

not entirely true, Mr. Chairman, and we can provide information to the committee sometime after the hearing, to demonstrate what is in place in the NAIC standards.

The third point that was made earlier in the day was the relevance of prior approval, and the number of rate increases and premium increases in those States in relationship to the States that do not have prior approval. Mr. Chairman, the information that was reported to us by many States shows there was no difference in the amount of premium increases in the nonprior approval versus prior approval States, and I just want to give that information to you.

The NAIC opposes, however, the Reform Act of 1990, because it will not alleviate the abuses which we have identified, namely, consumer confusion, duplication of coverage, twisting of policies, high-pressure tactics, and enforcement of loss ratio standards. Actually, we believe that the Reform Act will create a structure that has even greater potential for abuse than the current State regulatory environment. Our consumer protection amendments, which we urge to be included in the repeal of catastrophic legislation, do address the concerns that you have communicated to us. They will be adopted in the next few months by the States. As a matter of fact, 21 States have introduced legislation in their legislatures to implement these amendments, and as of today, I believe 3 States have actually finalized those amendments, and we have accomplished this all in less than 2 months.

The States have acted, we believe, in a very timely fashion, to repeal the Catastrophic Act; however, Federal agencies have not responded as quickly. The funding which appears necessary to carry out the reform act is lacking. The Department of Health and Human Services is unable to fulfill its current responsibilities in the Medicare supplement area, due to Federal budget cuts, much less accept new responsibilities. As an example, the NAIC and the Health Care Financing Administration coauthor a buyer's guide for Medicare supplement purchasers. Federal budget cuts prevented the Health Care Financing Administration from sending any copies of this buyer's guide to the States; in the past, they had provided 4,000 copies. The NAIC was informed of the budget cuts the second week in January, and within 2 weeks had printed and distributed 500 copies to each State department. The final printed version, even in the limited quantities now contemplated by the Health Care Financing Administration, still have not come off the printing press.

The NAIC is looking at standardized definitions. The NAIC addressed that issue last year, but, quite frankly, ran out of time in which to finish its work on this particular issue. The NAIC also addressed a complete standardization approach, but did not reach consensus among its members on which approach would serve the consumers of the country. In summary, the NAIC does oppose the medigap Reform Act of 1990, because it does not solve the ills with which we are both concerned. It, for the most part, just shifts the regulatory approval process to the Federal Government, and the potential for consumer abuse may even increase under this bill. I thank you for your attention, and if you have any questions, I'd be more than happy to answer them.

[The statement of Ms. Olson follows:]

STATEMENT OF CAROLE J. OLSON, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

INTRODUCTION

The National Association of Insurance Commissioners (NAIC) is a nonprofit organization which represents the chief regulatory officials of the 50 states, the District of Columbia, the territories and the insular possessions of the United States.

Mr. Chairman, you have long held interest in the topic of Medicare supplement insurance and we believe you have played a constructive role in the process by confirming the existence of abuses in the marketplace of which state regulators have been concerned. The NAIC is as concerned as you with companies that write policies that "rip off" our nation's elderly. Further, the NAIC is not going to defend any state that fails to act against these companies.

The NAIC, however, expresses strong opposition to the approach taken in the Medigap Reform Act of 1990 because we believe that the approach will add additional confusion to an already tumultuous marketplace, will not solve the abuses which you have identified and in fact will create a structure in which agent and company abuses may increase.

The goal of the NAIC, and the goal of Congress I believe, is to create an environment that facilitates the marketing of a product which meets minimum benefit, disclosure and performance standards. The environment should also protect against market abuses such as twisting, high pressure tactics and other unscrupulous activities.

To that end, the NAIC has over the last ten years consistently authored and sought implementation of standards that improved product quality and protected against abusive practices. The most recent example of this was our "Consumer Protection Amendments" which have been furnished to you (summary attached). We note that significant portions of those amendments have been included in your bill.

The following are very preliminary reactions to the Medigap Reform Act of 1990 which was introduced on March 8.

CONFUSED SENIOR CITIZENS

We agree with you that there is a confused elderly population out there trying to cope with the changes that have occurred over the last 18 months and to determine if they need to supplement their existing Medicare benefits. However, this bill will not ease that burden. Although the proposal attempts to assist the elderly by establishing a comparison shopping mechanism, the mechanism proposed does not accomplish that goal. Moreover, although the bill appears to standardize policies, it does so to a limited degree--little more than the existing state regulatory structure. The bill merely shifts the regulatory approval process to the federal government.

Given the turmoil in this environment, revisions to the regulatory structure should be carefully examined before they are adopted. Contributing to the turmoil will benefit no one and harm those to which we are both committed--our senior citizens.

FEDERAL REGULATION OF MEDICARE SUPPLEMENT INSURANCE

The Reform Act imposes nearly a total preemption of state regulation of Medicare supplement insurance and requires premium tax collection by the federal government on issuers of nonconforming policies. The dual regulation which remains under

the Act appears unworkable and it does not address the ills with which we are all concerned.

The NAIC is here today, as we have appeared many times in the past, to explain the function we serve in assisting states with the regulation of Medicare supplement insurance. The NAIC has made significant strides in recommending regulatory changes which we believe will further curb the abuses you have identified. We are also here to reassert that states do in fact regulate this market and will continue to do so to the extent authorized under the Reform Act, if enacted.

The dual regulatory approach has been tried before with ERISA. However, rather than strengthening consumer protection, the ERISA provisions have only served to confuse the regulatory jurisdiction between the state and federal governments which inhibits the protection of consumers. As a result, the effect of the well-intended ERISA law has been diluted in the area of health insurance.

The Reform Act supplies neither the staffing nor funding for the Secretary of Health and Human Services to carry out the responsibilities set forth in the proposal. The Department of Health and Human Services is unable to fulfill its current responsibilities in the Medicare supplement area due to federal budget cuts, much less accept new responsibilities. Fortunately the NAIC works closely with that agency and has been able to fill the gap created by these cuts. For example, we recently furnished 500 copies of the Buyer's Guide which were to have been distributed under federal law by the Health Care Financing Administration.

Another example of a federal standard which was adopted without accompanying resources is the COBRA law which provided for continuation of health insurance coverage in the event of terminations. Consumer and employer inquiries are now routinely being handled by the states in the absence of federal assistance.

STATE REGULATION OF MEDICARE SUPPLEMENT INSURANCE

The mission of the state insurance departments is, and always has been, consumer protection. On a daily basis over 6,000 state insurance department employees police the market and interact with consumers. Although the NAIC and the states pledge a continued cooperative spirit in working with the federal agencies should the bill be enacted, the bill will serve to stifle the ongoing activity in the states and result in further consumer confusion.

We believe the NAIC and the states have responded in a very timely fashion to the enactment and repeal of the Medicare Catastrophic Coverage Act. The states are now diligently working to implement these revisions and we expect that they will accomplished by December 13, 1990. Federal agencies have not responded as quickly. As you know, the Medicare supplement premium increases that Congress approved in connection with the Catastrophic Act are still being deducted from beneficiaries' checks. The federal tax forms still list the surtax.

At the same time the NAIC adopted revisions to conform to repeal of the Catastrophic Act, the NAIC moved forward by enacting "Consumer Protection Amendments." We believe these amendments will eliminate many of the concerns that you and the NAIC both have in this area. For example, the limit on agent commissions, the increased agent and company responsibilities concerning the sale of "appropriate" coverage and the prohibition against duplicative coverage go beyond what the Reform Act contemplates.

SUMMARY

The NAIC opposes the Medigap Reform Act of 1990 which preempts state regulation of Medicare supplement insurance. Although the bill is well intended, the NAIC believes that it will not address the concerns which have been identified by Congress and by the states. The bill, if enacted, will only contribute to an already confused elderly population.

Chairman STARK. Thank you very much.
Mr. Borman.

STATEMENT OF THOMAS H. BORMAN, COMMISSIONER OF COMMERCE, STATE OF MINNESOTA

Mr. BORMAN. Chairman Stark, and members of the subcommittee, I appreciate the opportunity to testify before you today. I will keep my remarks brief, both because of the lateness of the hour, and because I'm not sure my voice will last very long. I am the commerce commissioner for the State of Minnesota, and as such, I am charged with the responsibility of regulating Minnesota's financial industries, and that includes insurance, banking, securities and real estate. I am proud of what Minnesota has done on medigap. We have passed medigap laws that require loss ratio standards higher than the Baucus amendment. We have standardized medigap policies. We have leveled agent commissions, and we have a number of prohibitions on marketing abuses. Let me focus on statutory loss ratios, our policies in enforcing those, our use of standardized policies, and I think I will cut out the part on marketing abuses.

Two observations at the beginning: first of all, we have found substantial evidence in Minnesota that seniors are and have been paying more for medigap policies than is permitted under Minnesota's loss ratio standards. Those standards must be more aggressively enforced, and we intend to do so in Minnesota.

No. 2, meaningful price and benefit comparisons are of great utility to seniors, because they help prevent confusion and marketing abuses. Such comparisons are possible only if policy types are standardized and simplified.

The department is in the process now of completing a review of medigap loss ratios for policies sold in Minnesota. Following the Baucus amendment, the Minnesota Legislature enacted loss ratio standards that exceeded the Federal standards. We set a 65 percent loss ratio standard for individuals, and 75 percent for groups. But previously, the department relied on projections of loss ratio experience to justify premiums. In January, we reviewed the NAIC medigap experience exhibit, and I ordered, based on that, 12 companies whose mature pre-1985 business was substantially below our minimum loss ratio standard, to explain how they were going to achieve the 65 percent loss ratio; or alternatively, to file a plan of reduction. This week, I will be ordering several medigap carriers to roll back rates for renewal policies by up to 40 percent.

We are also directing medigap insurers to justify their rates and assumptions for two new policies offered in Minnesota as of January 1. Those are extended basic and basic. We anticipate further rate reductions for those, because the premiums for those policies were based, again, on projected experience, which in many cases has not been validated by actual experience.

I have also called for the legislature to help strengthen my department's enforcement powers in this area; specifically, legislations will be adopted which will require insurance companies to file annual loss ratio information. The legislation also clarifies our authority to order roll backs, where benefits paid fall short of statuto-

ry loss ratio. It also clarifies our right to order rollbacks based on actual, as opposed to projected, experience. It also raises the civil penalties that we can apply for violating loss ratio standards.

As has been noted this morning, we are one of the handful of States that has standardized medigap policies. We have two types of policies, basic coverage and extended basic coverage. The new policies standardize benefit coverage, and, we believe, allow seniors to make a direct comparison, and also encourage, price competition.

The standardized policies enabled my department to issue a meaningful cost comparison study on medigap. On February 1, 1990, I issued this 1990 Minnesota Medigap Insurance Cost Comparison Study. The study demonstrated differences in annual premiums for identical coverage of a household of up to $2,025. The company-by-company cost comparisons should promote both comparison shopping and competitive rates.

I think I am going to skip the rest of what I had in here, and answer questions. I appreciate the opportunity to share Minnesota's record with you; we are proud of it. I would be happy to answer any questions.

[The statement of Mr. Borman and attachments follow:]

STATEMENT OF THOMAS H. BORMAN, COMMISSIONER OF COMMERCE, STATE OF MINNESOTA

Chairman Stark and members of the Subcommittee. I appreciate the opportunity to testify before you today. My name is Thomas H. Borman and I am the Minnesota Commissioner of Commerce. As Commissioner I am charged with the responsibility of regulating Minnesota's financial industries including the insurance, banking, securities and real estate industries. I am proud that Minnesota is at the forefront nationally on medigap issues. Minnesota has passed medigap laws that require loss ratio standards higher than the Baucus Amendment, standardization of medigap policies, leveling of agent commissions, and prohibition of marketing abuses. Today I would like to focus on our experience in enforcing the statutory loss ratios, use of standardized policies, and prevention of market abuses.

Based on recent experience in Minnesota, I would make the following observations:

(1) We have found substantial evidence that Minnesota seniors are and have been paying more for medigap policies than is permitted under Minnesota's loss ratio standards. Those standards must be enforced more aggressively.

(2) Meaningful price and benefit comparisons are of great utility to seniors because they help prevent confusion and marketing abuses. However, such comparisons are possible only if policy-types are standardized and simplified.

The Department of Commerce is completing a review of medigap loss ratios for policies sold in Minnesota. Following the 1980 Baucus Amendment in Public Law 96-265, the Minnesota legislature enacted loss ratio standards that exceeded the federal standards. Minnesota's 1981 law required a minimum anticipated loss ratio of 65 percent on individual policies and 75 percent on group policies. Previously the Department relied on projections of loss ratio experience to justify premiums companies charged over a period of years.

In January, 1990, the Department reviewed the National Association of Insurance Commissioner's (NAIC) medigap experience exhibits of all medigap insurers issuing policies in Minnesota. I ordered twelve medigap insurers whose mature (pre-1985) business was substantially below the minimum statutory loss ratio standard to explain how they were going to achieve the 65 percent loss ratio or, alternatively, to file a plan of rate reduction. I will be ordering several medigap carriers to rollback rates for renewal policies by up to 40 percent.

All medigap insurers are also being ordered to justify their rates and assumptions for the new "Extended Basic" and "Basic" policies offered in Minnesota as of January 1, 1990. Further rate reductions are expected because the premiums for the new policies are based on projected experience, which in many cases, has not been validated by actual experience.

I have also called for legislation to help strengthen the Department's enforcement of Minnesota's medigap loss ratio standards. I have asked the legislature to require annual reporting of aggregate, actual experience; to determine compliance with loss ratio standards based on actual experience for mature (3 years) policies; and to clarify the Department's authority to order rollbacks and impose penalties. Specifically, the legislation will require insurance companies to file annual loss ratio information for each medigap policy form issued in Minnesota. The legislation clarifies our authority to order rollbacks where benefits paid out fall short of statutory loss ratios over three or more years experience. It also clarifies our right to order rollbacks based on actual as opposed to projected experience. Finally, the legislation clarifies the Department's power to impose civil penalties for violating loss ratios.

Minnesota is also one of a handful of states that has standardized medigap policies. The standardized policies provide meaningful benefits and prevent gross misrepresentations which can result with extremely diverse and complex policies. Minnesota's medigap law simplified the number of policy offerings in Minnesota from four categories to two categories. As of January 1, 1990, medigap policies sold in Minnesota must be either (1) "Basic" coverage or (2) "Extended Basic" coverage. "Basic" policies may have extra benefits added by optional rider. The new policies standardize benefit coverage and allow seniors to make a direct comparison of costs for identical benefit coverage. The standardized policies offer two primary levels of coverage and permit no alterations. The coverages of the Basic and Extended Basic policies are identified on Exhibit A attached hereto.

The standardization of policies enabled my Department to issue a meaningful cost comparison study on medigap policies in Minnesota. On February 1, 1990, I issued the 1990 Minnesota Medigap Insurance Cost Comparison Study which compared prices for identical medigap policies. The study demonstrated differences in annual premiums for identical coverage of a household of as much as $2,025. The company-by-company cost comparisons in the study should promote comparison shopping and competitive rates. It will also provide counseling and price information for Minnesota's more than 500,000 seniors. The Department will continue to review all rate filings and issue annual medigap cost comparison reports for consumers who wish to compare premium charges and loss ratios. We will also continue to work with senior advocacy groups to sponsor counseling workshops on insurance and investment issues.

The standardized policies also help prevent the sale of duplicate and replacement medigap coverage. Minnesota law prohibits replacement of a medigap policy with a duplicate policy unless there is substantial difference in cost favorable to the policyholder. If an agent sells a duplicate policy or provides unwarranted replacement coverage, that agent is guilty of a felony and subject to a civil penalty of up to $5,000 per violation. In addition, Minnesota law requires that a flat commission be paid to all agents for the first four years medigap policies are in force. The rationale for the level commission structure is to prevent any incentive for agents to seek the high first year commissions through fraudulent sales. Agents will not seek to profit at the expense of seniors by replacing existing adequate policies or by selling duplicate coverage rather than renewing seniors' present coverage.

Minnesota law requires agents to offer and explain both categories of medigap coverage and to determine the suitability of a recommended purchase of medigap prior to selling a policy. An outline of coverage must also be delivered at the time of application and prior to payment of any premium.

Again, Mr. Chairman, I appreciate the opportunity to share Minnesota's record with you. I would be happy to answer any questions which you or any other members of the Subcommittee may have.

THOMAS H. BORMAN

EXHIBIT A

All "Basic" policies will provide the following identical benefit coverage:

1. One hundred percent of Part A hospitalization expenses and co-payments. Basic policies do not cover the $592 Medicare Part A deductible per illness.

2. Pay Medicare Part A skilled nursing care co-payments.

3. Pay the Medicare blood deductible of three pints.

4. Pay the Medicare approved Part B co-payments.

Riders may be purchased to provide additional coverage for the basic policy. (Riders are not sold for Extended Basic coverage because they would duplicate benefits already covered in the policy.) Optional Riders to "Basic" coverage include:

1. Part A in-patient deductible. This extra benefit rider covers the $592 deductible for Medicare approved hospital expenses.

2. Part B annual deductible. This extra benefit rider covers $75 deductible for Medicare approved out-patient and physician services.

3. Eighty percent or one hundred percent of usual and customary. This extra benefit rider is offered at two alternative levels (80% or 100%) and pays the usual and customary hospital and medical expenses above those approved by Medicare.

4. Prescription drugs. This extra benefit rider covers fifty percent of the cost of prescription drugs not covered by Medicare.

All Extended Basic policies offered by companies provide identical benefit coverage. "Extended Basic" coverage is the most comprehensive coverage. It is even more comprehensive than a "Basic" policy with all optional riders. Extended Basic policies must provide all coverage provided by Basic policies plus the following coverage:

1. Pay one hundred percent of the $592 Medicare Part A deductible per illness.

2. Pay one hundred percent of $75 Medicare Part B deductible.

3. Pay the twenty percent of Part B Medicare approved charge, plus eighty percent of the usual and customary fees above Medicare's approved charge.

4. Have a $1,000 annual limit on money that must be paid out of pocket on covered medical expenses.

5. Have a lifetime maximum benefit of at least $500,000.

Medigap Insurance Cost Comparison Study

MINNESOTA Department of Commerce

January, 1990

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I. INTRODUCTION

As health care costs increase, seniors may find that the cost of medical services exceed Medicare coverage. Medicare covers part of the cost of medical care for the elderly but may not cover ALL of the costs. The purpose of Medicare Supplement Insurance (medigap) is to fill the gaps left by Medicare.

This study provides up-to-date information on medigap policies, their benefits, limitations and riders.

It also offers a price comparison of medigap policies sold in Minnesota. Consumers should use the specific price comparisons, the personal worksheet, and the list of insurers to comparison shop for medigap coverage that best meets their needs.

THE INCLUSION OR EXCLUSION OF A COMPANY IN THE STUDY DOES NOT INDICATE A RECOMMENDATION BY THE COMMISSIONER OF COMMERCE. THE COMPANIES INCLUDED IN THE STUDY FILED MEDIGAP POLICIES WITH THE DEPARTMENT AS OF JANUARY 25, 1990.

We hope this information is helpful. If you have questions about medigap insurance or would like more information, write to the Minnesota Commerce Department, 133 East 7th Street, St. Paul, Minnesota 55101 or call 612-296-2488 or our toll free number 1-800-652-9747.

II. WHO WILL BENEFIT FROM THIS GUIDE

This guide is directed to Minnesotans reaching age 65 or those who will be buying medigap policies for the first time.

IF YOU ALREADY HAVE A MEDIGAP POLICY, BEWARE OF REPLACING EXISTING COVERAGE. SENIORS THAT HAVE ANY SERIOUS HEALTH PROBLEMS SHOULD NOT CHANGE POLICIES. NEW POLICIES GENERALLY HAVE WAITING PERIODS AND WILL NOT COVER EXISTING HEALTH PROBLEMS FOR UP TO SIX MONTHS. IF, ON THE OTHER HAND, YOU ARE IN GOOD HEALTH AND WANT TO SHOP AROUND, THIS GUIDE WILL ASSIST YOU IN UNDERSTANDING THE CURRENT OFFERINGS. REMEMBER, YOU ARE NOT REQUIRED TO CHANGE POLICIES.

SENIORS WITH LOW INCOME MAY BE ELIGIBLE FOR MEDICAID AND WOULD NOT BENEFIT FROM A MEDIGAP POLICY. IF YOU HAVE QUESTIONS ABOUT MEDICAID, CONTACT YOUR COUNTY HUMAN SERVICES DEPARTMENT REGARDING ELIGIBILITY FOR MEDICAID.

THIS GUIDE DEALS ONLY WITH INSURANCE. COMPETITIVE HMO CONTRACTS MAY ALSO BE AVAILABLE (SEE PAGE 33).

III. GLOSSARY OF TERMS

CO-INSURANCE - THE PORTION OF THE APPROVED CHARGE NOT PAID BY MEDICARE AND WHICH IS THE RESPONSIBILITY OF THE PATIENT.

CUSTODIAL CARE - RESIDENTIAL NURSING HOME CARE WITHOUT SKILLED NURSING, ALSO KNOWN AS LONG TERM CARE.

DEDUCTIBLE - THAT PORTION OF THE BILL YOU MUST PAY BEFORE MEDICARE OR MEDIGAP.

MEDICALLY NECESSARY - THE PHYSICIAN DETERMINES THAT THE MEDICAL PROCEDURE OR SERVICE IS NECESSARY FOR THE PATIENT'S MEDICAL TREATMENT.

Medicare Approved - Medicare reimbursement has two components. First, Medicare determines whether the medical service is allowed. Second, Medicare determines the amount of charges allowed.

Medicare Part A - Hospital Insurance Plan - The Medicare Hospital Insurance Plan reimburses most hospital care and inpatient care in a skilled nursing facility.

Medicare Part B - Medical Insurance Plan - The Medicare Medical Insurance Plan reimburses physician-related fees and services.

Rider - The provisions added to the policy that are not contained in the policy contract. Riders may be added to Basic medigap policies to add benefits or coverage.

Skilled Nursing Facility - Doctor ordered care which requires a plan of treatment with daily care monitored by nurses.

Usual and Customary - The amount of reimbursement recognized by insurers as a standard charge for doctors' services. The usual and customary charges are often well above Medicare approved charges.

IV. THE NEED FOR MEDIGAP

The goal of medigap policies is to reduce your out-of-pocket exposure to medical costs not covered by Medicare. Before making a determination on whether to buy medigap insurance, it is important to know what benefits are covered by Medicare.

A. MEDICARE BENEFITS

MEDICARE IS THE FEDERAL HEALTH INSURANCE PROGRAM FOR SENIORS BEGINNING AT AGE 65 AND CERTAIN DISABLED CITIZENS. MEDICARE PAYS A LARGE PART OF SENIORS' HEALTH CARE EXPENSES BUT IT DOES NOT PAY THE FULL COST OF MEDICAL BILLS AND SERVICES. MEDICARE LOOKS AT THE SERVICE AND THE BILL ACTUALLY CHARGED FOR A SERVICE AND DETERMINES THE AMOUNT OF BENEFIT IT WILL APPROVE. SENIORS BILLED FOR AMOUNTS ABOVE THE MEDICARE APPROVED CHARGES PAY THE EXCESS CHARGES AS WELL AS THE MEDICARE DEDUCTIBLES AND THE CO-INSURANCE.

1. MEDICARE IS MADE UP OF TWO SEPARATE PARTS: HOSPITAL INSURANCE (CALLED PART A) AND MEDICAL INSURANCE (CALLED PART B).

   a. HOSPITAL INSURANCE (PART A):

      BENEFITS FOR MEDICARE HOSPITALIZATION SERVICES ARE THE MOST COMPREHENSIVE. EXCEPT FOR A $592 DEDUCTIBLE AND CO-INSURANCE, MEDICARE PAYS 100% OF THE CHARGES FOR THESE TYPES OF SERVICES WHEN MEDICALLY NECESSARY:

      1) INPATIENT HOSPITAL CARE UP TO 150 DAYS.

      2) INPATIENT SKILLED CARE AT A MEDICARE CERTIFIED SKILLED NURSING HOME.

      3) HOME HEALTH CARE SERVICES.

      NOTE: MOST OF AN ELDERLY PERSON'S HOSPITAL EXPENSES ARE PAID BY MEDICARE. THERE ARE ONLY SMALL GAPS IN PART A MEDICARE COVERAGE

THAT WILL REPRESENT OUT-OF-POCKET COSTS FOR SENIORS. THE PART A DEDUCTIBLE OF $592 IS A PER HOSPITALIZATION DEDUCTIBLE. IT IS NO LONGER AN ANNUAL DEDUCTIBLE. FOR EXAMPLE, IF YOU ARE HOSPITALIZED TWICE IN ONE CALENDAR YEAR YOU WILL PAY THE FIRST $592 FOR EACH VISIT OR $1,184 FOR DEDUCTIBLES.

B. MEDICAL INSURANCE (PART B):

FOLLOWING A $75 DEDUCTIBLE, MEDICARE PAYS 80% FOR THE FOLLOWING SERVICES WHEN MEDICALLY NECESSARY:

1) MEDICARE APPROVED CHARGES FOR DOCTOR'S SERVICES,

2) MEDICARE APPROVED OUTPATIENT HOSPITAL SERVICES,

3) MEDICARE APPROVED CHARGES FOR DIAGNOSTIC TESTING,

4) HOME HEALTH CARE VISITS,

5) MEDICARE APPROVED CHARGES FOR X-RAYS, RADIATION, AND PHYSICAL THERAPY,

6) CERTAIN EQUIPMENT, SUPPLIES, AND SERVICES SUCH AS WHEEL CHAIRS.

NOTE: FOR MEDICAL INSURANCE YOU PAY THE ANNUAL DEDUCTIBLE OF $75, 20% OF MEDICALLY NECESSARY SERVICES NOT REIMBURSED BY MEDICARE, AND THE DIFFERENCE BETWEEN THE ACTUAL DOCTOR'S SERVICES AND THE CHARGES APPROVED BY MEDICARE.

DOCTOR'S BILLS HIGHER THAN THE MEDICARE "APPROVED" CHARGE ARE ONE OF THE BIGGEST GAPS IN MEDICARE COVERAGE.

B. COST AND COVERAGE GAPS IN MEDICARE

1. HOSPITAL EXPENSES NOT PAID BY MEDICARE

A. YOU PAY THE FIRST $592 WITH EACH HOSPITAL STAY. YOU PAY $148 DAILY FROM THE 61ST TO THE 90TH DAYS OF HOSPITALIZATION. YOU PAY THE FIRST $296 PER DAY FROM THE 91ST TO THE 150TH DAY OF HOSPITALIZATION. YOU PAY ALL OF THE COSTS AFTER THE 150TH DAY OF HOSPITALIZATION.

B. YOU PAY $74 PER DAY FROM THE 21ST TO THE 100TH DAY OF A MEDICARE-APPROVEDED SKILLED NURSING HOME STAY. YOU PAY ALL OF THE COSTS FOR SKILLED CARE AFTER THE 100TH DAY.

C. YOU PAY FOR ALL CUSTODIAL NURSING HOME CARE OR CARE IN A NONCERTIFIED SKILLED NURSING HOME.

D. YOU PAY FOR PRIVATE-DUTY NURSING.

E. YOU PAY FOR ANY SERVICES NOT MEDICALLY NECESSARY. EXAMPLES INCLUDE A PRIVATE ROOM IN A HOSPITAL OR SKILLED NURSING HOME, A TELEPHONE OR TELEVISION.

2. PHYSICIAN'S EXPENSES NOT PAID BY MEDICARE

A. YOU PAY THE YEARLY DEDUCTIBLE OF $75 FOR COVERED MEDICAL EXPENSES,

B. You pay the difference between the 100% and 80% of the Medicare approved charges for medical services,

C. You pay the difference between the Medicare approved charges and the actual charges by the doctor,

D. You pay for drugs and medicines seniors buy themselves (not given in the hospital),

E. You pay for regular physical examinations,

F. You pay for dental care,

G. You pay for hearing aids and routine hearing loss examinations, and

H. You pay for eye glasses and regular eye examinations.

NOTE: Senior citizens have reported that the three main gaps in Medicare coverages are:

A. The Part B Medical Insurance

B. Prescription Drugs

C. Nursing Care.

Comparison of how the Medigap policies offered in Minnesota can fill these gaps is addressed on pages 11-15.

V. THE MEDIGAP POLICIES SOLD IN MINNESOTA

As of January 1, 1990, medigap policies sold in Minnesota must be either (1) "Basic" coverage or (2) "Extended Basic" coverage. "Basic" policies may have extra benefits added by optional rider.

SPECIFIC COMPARISON OF BASIC COVERAGE AND EXTENDED BASIC COVERAGE

A. BASIC POLICY COVERAGE

Basic policies while the least comprehensive must provide the following coverage:

1. 100% of Part A hospitalization expenses and co-payments. Basic policies DO NOT cover the $592 Medicare Part A deductible per illness.

2. Pay Medicare Part A skilled nursing care co-payments.

3. Pay the Medicare blood deductible of 3 pints.

4. Pay the Medicare approved Part B co-payments.

All Basic policies without riders will offer identical benefit coverage. This allows you to directly compare the costs of Basic medigap policies.

B. OPTIONAL RIDERS FOR BASIC POLICY COVERAGE

Riders may be purchased to provide additional coverage for the Basic policy. (Riders are not sold for Extended Basic Coverage because they would duplicate benefits already covered in the policy.)

Optional Riders to "Basic" Coverage:

1. Part A Inpatient Deductible - This extra benefit rider covers the $592 deductible for Medicare approved hospital expenses.

2. Part B Annual Deductible - This extra benefit rider covers the $75 deductible for Medicare approved outpatient and physician services.

3. 80% or 100% of Usual & Customary - This extra benefit rider is offered at two alternative levels (80% or 100%) and pays the usual and customary hospital and medical expenses above those approved by Medicare.

4. Prescription Drugs - This extra benefit rider covers 50% of the cost of prescription drugs not covered by Medicare. This rider is not presently offered by any Minnesota insurer.

C. EXTENDED BASIC COVERAGE

Extended Basic Coverge is the most comprehensive coverage. It is even more comprehensive than a "Basic" policy with all optional riders. Extended Basic policies must provide all coverage provided by Basic policies plus the following coverage:

1. Pay 100% of the $592 Medicare Part A deductible per illness.

2. Pay 100% of $75 Medicare Part B deductible.

3. Pay the 20% of Part B Medicare approved charge, plus 80% of the usual and customary fees above Medicare's approved charge;

4. Have a $1,000 annual limit on money you must pay out of your own pocket on covered medical expenses; and

5. Have a lifetime maximum benefit of at least $500,000.

All Extended Basic Policies offered by companies offer identical benefit coverage. This allows you to directly compare the cost of Extended Basic medigap policies.

VI. COMPARING FORMER 1+, 1, 2 OR 3 POLICIES WITH BASIC AND EXTENDED BASIC POLICIES

Under Minnesota's former rating system (prior to January 1, 1990), all medigap policies were labelled 1+ (most comprehensive), 1, 2, or 3 (least comprehensive). If you have one of these existing policies, you should know the following comparisons to new policies:

Coverage	Former Rating	vs	NEW rating
Most Comprehensive	"1+" supplement	=	an "Extended Basic" policy
	"1" supplement	=	an "Extended Basic" policy with slightly less doctor bill coverage
	"2" supplement	=	a "Basic" policy with one optional riders

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LEAST COMPREHENSIVE	"3" SUPPLEMENT	=	A "BASIC" POLICY WITHOUT RIDERS

REMEMBER, ALL EXISTING POLICIES MUST CONFORM TO THE NEW MEDICARE LAW. YOU ARE NOT REQUIRED TO CHANGE POLICIES.

VII. THREE MAIN GAPS IN MEDICARE

THREE AREAS WHERE SENIORS' OUT-OF-POCKET EXPENSES MAY BE THE GREATEST ARE:

A. PART B MEDICAL INSURANCE
B. PRESCRIPTION DRUGS
C. NURSING CARE

A. PART B MEDICAL INSURANCE

1. MEDICARE:

FOR MOST PHYSICIANS' SERVICES, FOLLOWING THE $75 ANNUAL DEDUCTIBLE MEDICARE PAYS 80% OF THE MEDICARE APPROVED CHARGE. PATIENTS ARE RESPONSIBLE FOR THE REMAINING 20%, PLUS ANY FEE IN EXCESS OF THE APPROVED CHARGE.

2. COMPARING MEDIGAP POLICIES' COVERAGE OF PART B MEDICAL INSURANCE

a. BASIC COVERAGE

1) BASIC COVERAGE PAYS 20% OF THE MEDICARE APPROVED MEDICAL CHARGES.

2) BASIC COVERAGE DOES NOT PAY FOR ANY CHARGES IN EXCESS OF THE MEDICARE APPROVED CHARGES.

B. Basic Coverage With Optional Riders

1) Pays 20% of the Medicare approved medical charge.

2) Optional riders to pay:

A) $75 annual deductible for Medicare approved charges for outpatient and physician services.

B) 80% or 100% of usual and customary medical expense above those approved by Medicare.

C) 50% of the cost of prescription drugs not covered by Medicare.

C. Extended Basic Coverage

1) Extended Basic Coverage pays 20% of the approved medical charges, and

2) Extended Basic Coverage pays 80% of the difference between the doctors usual and customary charge and the Medicare approved charge.

3. Part B Medical Insurance Example with Specific Dollar Comparisons

A. Part B Medical Insurance Example: Assume that your physician charges $1,000 for services but, under Medicare's payment scheme $600 is the approved charge.

YOU PAY THE $75 DEDUCTIBLE. MEDICARE WOULD PAY 80% OF THE REMAINING $525 ALLOWABLE CHARGE, OR $420. THE DIFFERENCE BETWEEN YOUR ACTUAL DOCTOR'S CHARGE OF ($1,000) AND THE AMOUNT PAID BY MEDICARE ($420) WOULD LEAVE A GAP OF $580.

B. COMPARING MEDIGAP POLICIES' COVERAGE OF THE PART B MEDICAL EXPENSE IN THE EXAMPLE:

1. BASIC COVERAGE WOULD PAY 20% OF THE MEDICARE APPROVED CHARGE OF $525. BASIC COVERAGE PAYS $105. YOU PAY THE DEDUCTIBLE ($75) AND THE AMOUNT ABOVE MEDICARE APPROVED CHARGES ($400). YOU PAY $475.

2) BASIC COVERAGE WITH A PART B DEDUCTIBLE RIDER WOULD PAY 20% OF MEDICARE APPROVED CHARGES ($105) AND THE DEDUCTIBLE ($75). THE POLICY PAYS A TOTAL OF $180. YOU MAY PAY THE AMOUNT ABOVE MEDICARE APPROVED CHARGES. YOU PAY $400.

3) BASIC COVERAGE WITH A 80% OF USUAL AND CUSTOMARY RIDER WOULD PAY 20% OF MEDICARE APPROVED CHARGES ($105) AND 80% OF THE USUAL AND CUSTOMARY FEES ABOVE MEDICARE APPROVED CHARGES ($320). THE POLICY PAYS $425. YOU WOULD PAY THE $75 DEDUCTIBLE AND 20% OF THE FEES ABOVE MEDICARE APPROVED CHARGES ($80). YOU PAY $155.

4) BASIC COVERAGE WITH PART B DEDUCTIBLE RIDER AND 80% OF USUAL AND CUSTOMARY RIDER. THE POLICY WOULD PAY 20% OF

APPROVED CHARGES ($105), THE $75 DEDUCTIBLE, AND 80% OF THE USUAL AND CUSTOMARY FEES ABOVE MEDICARE APPROVED CHARGES ($320). THE POLICY PAYS $500. YOU PAY 20% OF THE USUAL AND CUSTOMARY FEES ABOVE MEDICARE APPROVED CHARGES. YOU PAY $80.

5) EXTENDED BASIC COVERAGE WOULD PAY 20% OF APPROVED CHARGES ($105), THE $75 DEDUCTIBLE AND 80% OF THE USUAL AND CUSTOMARY FEES ABOVE MEDICARE APPROVED CHARGES ($320). THE POLICY PAYS $500. YOU PAY 20% OF THE USUAL AND CUSTOMARY FEES ABOVE MEDICARE APPROVED CHARGES. YOU PAY $80.

B. PRESCRIPTION DRUGS

1. MEDICARE

PRESCRIPTION DRUGS ARE PART OF THE HOSPITALIZATION COSTS COVERED BY MEDICARE WHILE THE PATIENT IS IN THE HOSPITAL. ONCE THE SENIOR LEAVES THE HOSPITAL, MEDICARE NO LONGER PAYS FOR PRESCRIPTION DRUGS.

2. COMPARING MEDIGAP POLICIES' COVERAGE OF PRESCRIPTION DRUGS THAT SENIORS BUY THEMSELVES.

A. BASIC COVERAGE DOES NOT PAY FOR PRESCRIPTION DRUGS.

B. BASIC COVERAGE WITH AN OPTIONAL RIDER WILL COVER AT LEAST 50% OF THE PRESCRIPTION DRUG COSTS. A PRESCRIPTION DRUG RIDER IS CURRENTLY

NOT OFFERED BY COMPANIES WRITING BASIC COVERAGE IN MINNESOTA.

c. EXTENDED BASIC COVERAGE WILL PAY FOR 80% OF YOUR PRESCRIPTION DRUG COSTS.

ONE OF THE BIGGEST QUESTIONS SENIORS WILL NEED TO ASK THEMSELVES IS WHETHER THEY WANT PRESCRIPTION DRUG COVERAGE. IF YOU USE PRESCRIPTION DRUGS YOU SHOULD CONSIDER THE EXTENDED BASIC PLAN. IF YOU ARE NOT CURRENTLY USING PRESCRIBED MEDICATION, IT MAY BE BETTER TO SAVE YOUR MONEY.

C. NURSING CARE - CUSTODIAL, INTERMEDIATE AND SKILLED CARE IN A NURSING HOME

BOTH BASIC AND EXTENDED BASIC POLICIES COVER THE CO-PAYMENTS FOR SKILLED CARE IN THE NURSING HOME. HOWEVER, NEITHER BASIC NOR EXTENDED BASIC POLICIES COVER INTERMEDIATE AND CUSTODIAL CARE IN A NURSING HOME. MEDIGAP POLICIES ALSO DO NOT COVER PRIVATE DUTY NURSES OR LONG-TERM SKILLED NURSING CARE BEYOND 100 DAYS (120 DAYS FOR THE EXTENDED BASIC). SEPARATE LONG-TERM CARE POLICIES ARE SOLD BY SOME CARRIERS TO PAY NURSING HOME EXPENSES AND ARE NOT DISCUSSED IN THIS GUIDE.

VIII. CONSUMER SHOPPING TIPS

1. **COMPARE THE COSTS AND BENEFITS OF BASIC AND EXTENDED BASIC POLICIES.** AN AGENT MUST PRESENT THE MORE COMPREHENSIVE EXTENDED BASIC COVERAGE TO YOU PRIOR TO SELLING ANY OTHER MEDIGAP POLICY.

2. DON'T ASSUME YOU SHOULD DROP YOUR EXISTING MEDIGAP POLICY JUST BECAUSE OF RECENT CHANGES IN THE LAW. IF YOU ARE IN POOR HEALTH, DON'T DROP YOUR EXISTING MEDIGAP POLICY.

3. WHEN COMPARING BASIC AND EXTENDED BASIC POLICY COVERAGES:

   ° ASK HOW MUCH OF THE PART A HOSPITAL CHARGE WILL BE COVERED AND WHETHER THE POLICY PAYS FOR THE HOSPITAL DEDUCTIBLE. (AS OF JANUARY, 1990, THIS DEDUCTIBLE IS $592 PER ILLNESS).

   ° ASK HOW MUCH OF THE ACTUAL DOCTORS' CHARGES IN EXCESS OF THE MEDICARE "APPROVED" AMOUNT WILL BE COVERED UNDER THE POLICY. EXCESS DOCTOR FEES TODAY REPRESENT ONE OF THE BIGGEST GAPS IN MEDICARE COVERAGE.

   ° ASK IF THE POLICY PAYS THE PART B MEDICAL EXPENSE DEDUCTIBLE. (AS OF JANUARY, 1990 THIS DEDUCTIBLE IS $75 ANNUALLY).

   ° ASK HOW MUCH THE POLICY PAYS FOR PRESCRIPTION DRUGS THAT YOU BUY YOURSELF.

   ° BE CAREFUL ABOUT BUYING POLICIES ON THE BASIS OF THEIR NURSING HOME COVERAGE. MEDICARE AND MEDIGAP POLICIES DO NOT COVER LONG-TERM SKILLED NURSING CARE BEYOND 100 DAYS, CUSTODIAL NURSING HOME CARE OR PRIVATE DUTY NURSES. SEPARATE LONG-TERM CARE POLICIES CAN BE PURCHASED.

4. DON'T LISTEN TO ANYONE WHO TELLS YOU THAT THE MEDIGAP POLICY PAYS FOR EVERYTHING WHICH MEDICARE DOES NOT PAY. NO SUCH POLICY EXISTS.

5. **Insist on an outline of coverage which describes the benefits offered.** Under Minnesota law, this outline must be given to you when you apply for health insurance and before you pay. Read it carefully. A signed and completed copy of your application for insurance must be left with you at the time of application.

6. **Never buy more than one Medigap policy.** It is illegal for a company or agent to sell you a second or duplicate Medigap policy.

7. **Deal with a local agent or company you know.** Write down names, addresses and phone numbers. To check on an agent's license, call the Commerce Department Licensing Unit at (612) 296-6319.

8. **Take your time and ask lots of questions.** Be suspicious of anyone who tries to rush your decision. Speak with family members, friends, other seniors, senior advocates, and compare before you buy.

9. **Never pay with cash.** Write a check or money order payable to the company, **not** the agent.

10. **Read your Medigap policy carefully after you receive it.** If for any reason you wish to cancel the policy, you should return it to the agent or insurance company by registered mail within 30 days of receiving it. All of your money must be returned to you within ten working days.

11. **If you have a serious health problem, consider MCHA.** People who have been rejected for coverage because of health history or who are charged a higher than standard rate for a Medigap policy qualify for the

Minnesota Comprehensive Health Association (MCHA) medigap coverage. For information or an application, call MCHA at (612) 456-5290, or at toll free 1-800-382-2000, extension 5290.

IX. How to Use the Benefit and Cost Comparison Tables and Worksheet

A. Benefit Comparison Tables

1. Determine the type of policy you desire by reviewing the Benefit Comparison tables on pages 22 and 23.

   Choose either:
   - Basic
   - Basic with Optional Riders, or
   - Extended Basic

B. Cost Comparison Tables

1. Locate the Cost Comparison Table with the policy coverage you choose. (See heading at top of table: Basic; Optional Riders; Extended Basic).

2. Locate your sex and age (at the top of the table)

3. Below the comparisons for sex and age are the low, high and average rate. These rates are listed as a starting point to assist you in shopping for the most competitive policy for your needs.

4. Company-by-company cost comparisons are summarized in the tables. Find the three lowest premium companies for you. Write these company names on the worksheet.

5. Contact the companies or their agents to obtain <u>written</u> summaries and outlines of coverage on the policy and possible added riders.

6. Discuss whether your health history will pose any problem in qualifying. Apply to the carrier that you choose.

THE MEDIGAP STUDY DEMONSTRATES THE TREMENDOUS DIFFERENCE IN PREMIUMS CHARGED FOR IDENTICAL COVERAGE.
COMPARISON EXAMPLES (as of January 1990)

<u>Example One</u>: (A 67 year old non-smoking woman) would pay between $178 per year (Blue Cross and Blue Shield of Minnesota) and $459 per year (American Family Life Assurance Company of Columbus) for <u>identical Basic coverage before riders</u>.

She would pay between $775 per year (Blue Cross & Blue Shield of Minnesota) and $1,850 per year (Combined Insurance Company of America) for <u>identical Extended Basic coverage</u>.

<u>Example Two</u>: (A 72 year old smoking man) would pay between $287 per year (Blue Cross and Blue Shield of Minnesota) and $480 per year (American Life Assurance Commpany of Columbus) for <u>identical Basic coverage before riders</u>.

He would pay between $1,252 per year (Blue Cross and Blue Shield of Minnesota) and $2,204 per year (Combined Insurance Company of America) for <u>identical Extended Basic coverage</u>.

Example Three: A couple (a 66 year old non-smoking woman and a 72 year old non-smoking man), buying "Basic" policies with two riders: (1) for the $592 Part A deductible, and (2) for 80% of the usual and customary fees above Medicare approved charges, would pay between $1,162 per year (Blue Cross and Blue Shield of Minnesota) and $1,794 per year (Medico Life Insurance Company), a difference of $662.

Note that this couple could have purchased Extended Basic policies (much better coverage) for just $38 more than the expensive (Medico) Basic policy with these two riders.

Example Four: (A 85 year old smoking man) would pay between $328 per year (Blue Cross and Blue Shield of Minnesota) and $650 per year (Continental General Insurance Company) for identical Basic coverage before riders.

He would pay between $1,468 per year (Minnesota Comprehensive Health Association) and $2,527 per year (Mutual of Omaha) for identical Extended Basic coverage.

MEDICARE SUPPLEMENT INSURANCE WORKSHEET

	Company A	Company B	Company C
Company Name:			
Agent Name:			
Phone:			
I **"Basic" Policy**	Form # _____	Form # _____	Form # _____
"Basic" Policy Cost:	$_____	$_____	$_____
Optional Riders:			
(1) Part A in-patient deductible	(1) _____	(1) _____	(1) _____
(2) Part B annual deductible	(2) _____	(2) _____	(2) _____
(3) 80% or 100% of Medical expenses not eligible for Part B (i.e. doctor bills not approved by Medicare)	(3) _____ Covers _____%	(3) _____ Covers _____%	(3) _____ Covers _____%
(4) Prescription drugs not covered by Medicare	(4) _____	(4) _____	(4) _____
TOTAL:	$_____	$_____	$_____
II **"Extended Basic" Policy**	Form # _____	Form # _____	Form # _____
(More Comprehensive than a "Basic" policy with all optional riders)			
"Extended Basic" Policy Cost:	$_____	$_____	$_____

BENEFIT COMPARISON TABLE

MEDICARE (PART A): HOSPITAL INSURANCE - COVERED SERVICES PER ILLNESS

SERVICE	BENEFIT	MEDICARE PAYS
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services	First 60 days	All but $592
	61st to 90th day	All but $148 a day
	91st to 150th day	All but $296 a day
	Beyond 150 days	Nothing
POSTHOSPITAL SKILLED NURSING FACILITY CARE In a facility approved by Medicare. You must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge. (1)	First 20 days	100% of approved amount
	Additional 80 days	All but $74 a day
	Beyond 100 days	Nothing
HOME HEALTH CARE	Visits limited to medically necessary skilled care	Full cost of services 80% of approved medical equipment
HOSPICE CARE for terminally ill	Up to 210 days if doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care.
BLOOD	Blood	All but first 3 pints

MEDICARE (PART B): MEDICAL INSURANCE - COVERED SERVICES PER YEAR

SERVICE	BENEFIT	MEDICARE PAYS
MEDICAL EXPENSE Physicians's services, inpatient and OUTPATIENT MEDICAL SERVICES and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $75 deductible)
HOME HEALTH CARE	Visits limited to medically necessary skilled care	Full cost of services 80% of approved medical equipment (after $75 deductible)

(1) Medicare and private insurance will not pay for most nursing home care. You pay for custodial care and most care in a private nursing home.

*After $75 of expense for covered services in one year, the Part B deductible does not apply for the rest of the year.

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BENEFIT COMPARISON TABLE

MEDICARE (PART A): HOSPITAL INSURANCE - COVERED SERVICES PER ILLNESS

YOU PAY*	EXTENDED BASIC COVERAGE	BASIC COVERAGE
$592	Covers $592 deductible	Does not cover $592 deductible.
$148 a day $296 a day All costs	$148 a day $296 a day All costs	$148 a day $296 a day All costs Optional Rider: $592 deductible
Nothing for first 20 days		
$74 a day from 21st to 100th day	Covers $74 from 21st to 120th day	Covers $74 from 21st to 100th day.
All expenses after 100th day	Nothing after 120th day	Nothing after 100th day.
Nothing for services		
Limited cost sharing for outpatient drugs and inpatient respite care	Nothing	Nothing
For first 3 pints	Covers 3 pints	Covers 3 pints

MEDICARE (PART B): MEDICAL INSURANCE - COVERED SERVICES PER YEAR

YOU PAY*	EXTENDED BASIC COVERAGE	BASIC COVERAGE
$75 deductible* plus 20% of balance of approved amount (plus any charge above approved amount)**	Covers 20% of Medicare approved charges and $75 deductible.	Covers 20% of Medicare approved charges. Optional Rider: $75 deductible
Nothing for services 20% of approved amount durable medical equipment (after $75 deductible)	Covers 80% of usual and customary hospital, medical expenses and supplies and prescription drugs not covered by Medicare.	Optional Rider: 80% or 100% of usual and customary medical expenses not covered by Medicare. Optional Rider: 50% of prescription drugs.

** YOU PAY charges higher than the amount approved by Medicare unless the doctor or supplier accepts Medicare's approved amount for services rendered.

COST COMPARISON TABLES

"BASIC" RATES (without optional riders)
Both Male and Female by Age

Company	65	70	75	80	85
LOW $	178	228	261	261	261
HIGH $	459	450	500	579	650
AVER $	355	403	448	490	511
Blue Cross and Blue Shield of MN (Form # F4465) P.O. Box 64560 St. Paul, MN 55164 (612) 456-5030			Female non-smoker		
	178	228	261	261	261
			smoker		
	224	287	328	328	328
			Male non-smoker		
	193	243	276	276	276
			smoker		
	243	306	348	348	348
American Republic Insurance Co. (Form # A2994) Des Moines, IA 50334 (515) 247-2190	307	346	402	435	477
Central States Health and Life Insurance Co. (Form # 567) P.O. Box 34350 Omaha, NE 68134 (402) 397-1111	305	358	422	422	422
Continental General Insurance Company (Form # 329) 8901 Indian Hills Omaha, NE 68114 (402) 397-3200	367	427	480	564	650

COST COMPARISON TABLES

"BASIC" RATES without optional riders (continued)
Both Male and Female by Age

Company	65	70	75	80	85
Mutual of Omaha Insurance Co. (Form # M139) Mutual of Omaha Plaza Omaha, NE 68175 (402) 342-7600	305	372	406	444	444
Guarantee Trust Life Ins. Co. (Form # 90421) 1275 Milwaukee Glenview, IL 60025 (312) 699-0600	403	441	480	515	572
Combined Ins. Co. (Form # 14962) 123 N. Wacker Dr. Chicago, IL 60606 (312) 701-3833	432	477	500	500	500
Medico Life Ins. (Form # ML4890(MN) 1515 S. 75th St. Omaha, NE 68124 (402) 391-6900	385	436	500	579	579
Mutual Protective Insurance Co. (Form # MP4890(MN) 1515 S. 75th St. Omaha, NE 68124 (402) 391-6900	385	436	500	579	579
American Family Life Assurance Co. of Columbus 1932 Wynnton Rd Columbus, CA 31999 1-800-622-2345	459	480	496	565	591

This Rate Chart was prepared on January 24, 1990 and contains companies that had rates filed on this date.

COST COMPARISON TABLES

OPTIONAL RIDERS TO "BASIC" POLICY, BY COMPANY
($ range from age 65 to 85)
Both Female and Male

Company	* Part A Deduct	* Part B Deduct	* 80% U&C	* 100% U&C
LO $ range, age 65 to 85	87 to 128	39 to 57	226 to 332	207 to 300
HI $ range, age 65 to 85	232 to 392	60	308 to 450	385 to 563
AVER $ range, age 65 to 85	193 to 305	55 to 60	257 to 393	282 to 407
Blue Cross and Blue Shield of MN (Form # F4465) P.O. Box 64560 St. Paul, MN 55164 (612) 456-5030		Female non-smoker		
	87 to 128	39 to 57	226 to 332	NA
		Female smoker		
	110 to 161	49 to 60	285 to 417	NA
		Male non-smoker		
	95 to 136	42 to 60	246 to 351	NA
		Male smoker		
	119 to 171	53 to 60	309 to 441	NA
American Republic Insurance Co. (Form # A2994) Des Moines, IA 50334 (515) 247-2190	177 to 350	57	254 to 434	273 to 467

* Key: **Part A Deduct** - pays $592 deductible per illness for Medicare approved hospital expenses. **Part B Deduct** - pays the $75 deductible per year for Medicare approved outpatient and physician services **80% U&C and 100% U&C** pays 80% or 100% of the usual and customary hospital and medical expenses above those approved by Medicare.

COST COMPARISON TABLES

OPTIONAL RIDERS TO "BASIC" POLICY, BY COMPANY (continued)
($ range from age 65 to 85)
Both Female and Male

Company	* Part A Deduct	* Part B Deduct	* 80% U&C	* 100% U&C
Central States Health and Life Insurance Co. (Form # 567) P.O. Box 34350 Omaha, NE 68134 (402) 397-1111	220 to 346	NA	265 to 350	360 to 470
Continental General Ins. Co. (Form # 329) 8901 Indian Hills Omaha, NE 68114 (402) 397-3200	232 to 392	NA	NA	207 to 300
Mutual of Omaha Insurance Co. Form # M139) Mutual of Omaha Plaza Omaha, NE 68175 (402) 342-7600	203 to 296	NA	308 to 450	385 to 563
Guarantee Trust Life Ins. Co. (Form # 90421) 1275 Milwaukee Glenview, IL 60025 (312) 699-0600	181 to 280	NA	NA	215 to 361
Combined Ins. Co. (Form # 14962) 123 N. Wacker Dr. Chicago, IL 60606 (312) 701-3833	181 to 263	60	NA	250 to 278

* **Key:** **Part A Deduct** - pays $592 deductible per illness for Medicare approved hospital expenses. **Part B Deduct** - pays the $75 deductible per year for Medicare approved outpatient and physician services **80% U&C and 100% U&C** pays 80% or 100% of the usual and customary hospital and medical expenses above those approved by Medicare.

COST COMPARISON TABLES

OPTIONAL RIDERS TO "BASIC" POLICY, BY COMPANY (continued)
($ range from age 65 to 85)
Both Female and Male

Company	* Part A Deduct	* Part B Deduct	* 80% U&C	* 100% U&C
Medico Life Ins. (Form # ML4890(MN) 1515 S. 75th St. Omaha, NE 68124 (402) 391-6900	223 to 335	NA	228 to 369	NA
Mutual Protective Insurance Co. (Form # MP4890(MN) 1515 S. 75th St. Omaha, NE 68124 (402) 391-6900	223 to 335	NA	228 to 369	NA
American Family Life Assurance Co. of Columbus (Form # A-19000-6) 1932 Wynnton Road Columbus, GA 31999 1-800-622-2345	220 to 376	NA	NA	280 to 368

* **Key:** **Part A Deduct** - pays $592 deductible per illness for Medicare approved hospital expenses. **Part B Deduct** - pays the $75 deductible per year for Medicare approved outpatient and physician services **80% U&C and 100% U&C** pays 80% or 100% of the usual and customary hospital and medical expenses above those approved by Medicare.

This Rate chart was prepared on January 24, 1990 and contains companies that had rates filed on this date.

COMMERCE DEPARTMENT
1990 MINNESOTA MEDIGAP INSURANCE COST COMPARISON STUDY
MARCH 12, 1990 INSERT

CORRECTION, PAGE 28. The price range shown for Medico Life Insurance and Mutual Protective Insurance for 80% U & C Optional Rider should be under the next column for 100% U & C.

ADDITIONAL COMPANY INFORMATION: (RATES PER YEAR)

United American Insurance Company
2909 N. Buckner Blvd.
Dallas, TX 75221-08100
(214) 328-2841
Extended Basic (Form CATMS (22-01) R1289); Basic (Form MCI R1289)

Age	"Extended Basic"	"Basic"	Part A Deduct Rider	80% U &C Rider
65-74	$1672	$517	$242	$220
75-79	1672	561	253	231
80+	1672	616	286	242

MidAmerica Mutual Life Insurance Company
1801 West County Road B
Roseville, MN 55113
(612) 631-1075
Extended Basic (Form 00736); Basic (Form 00726)

Age	"Extended Basic"	"Basic"	Part A Deduct	Part B Deduct	100% U & C	75% Drugs
65-69	$1110	$277.50	$166.50	$55.50	$277.50	$277.50
70-74	1277	333.50	188.70	55.50	333.00	333.00
75 +	1499	388.50	222.00	55.50	388.50	388.50

ADDITIONAL COMPANY INFORMATION: (RATES PER YEAR)

CONTINENTAL GENERAL INSURANCE COMPANY
8901 INDIAN HILLS DRIVE
OMAHA, NE 68114
(402) 397-3200
BASIC (FORM 331)

AGE	"BASIC"	PART A DEDUCTIBLE	100% U & C
65-69	$343	$149 - $250	$207 - $300
70-74	402		
75-79	465		
80-84	525		
85+	593		

PHYSICIANS MUTUAL INSURANCE COMPANY
2600 DODGE
OMAHA, NE 68131
(402) 633-1000
BASIC (FORM P116 REV. 1-90)

AGE	"BASIC"	PART A DEDUCTIBLE	PART B DEDUCTIBLE	100% U & C
65-69	$406	$264 - $375	$52 - $59	$293 - $355
70-79	469			
80+	504			

COST COMPARISON TABLES

"EXTENDED BASIC" RATES
Both Male and Female by Age

Company	65	70	75	80	85
LOW $	775	991	1135	1135	1135
HIGH $	1850	2204	2491	2526	2526
AVER $	1365	1569	1749	1858	1883
Blue Cross and Blue Shield of MN (Form # F4464) P.O. Box 64560 St. Paul, MN 55164 (612) 456-5030		**Female non-smoker**			
	775	991	1135	1135	1135
		Female smoker			
	979	1252	1434	1434	1434
		Male non-smoker			
	841	1057	1201	1201	1201
		Male smoker			
	1062	1335	1518	1518	1518
American Republic Insurance Co. (Form # A2995) Des Moines, IA 50334 (515) 247-2190	1204	1378	1569	1734	1892
Central States Health and Life Insurance Co. (Form # 568) P.O. Box 34350 Omaha, NE 68134 (402) 397-1111	1050	1260	1560	1560	1560
Minnesota Comprehensive Health Association (Form # 4495) P.O. Box 64566 St. Paul, MN 55164 (612) 456-5290	1468	1468	1468	1468	1468

COST COMPARISON TABLES

"EXTENDED BASIC" RATES (continued)
Both Male and Female by Age

Company	65	70	75	80	85
Continental General Ins. Co. (Form # 330) 8901 Indian Hills Omaha, NE 68114 (402) 397-3200	1400	1600	1800	2030	2350
Mutual of Omaha Insurance Co. (Form # M138) Mutual of Omaha Plaza Omaha, NE 68175 (402) 342-7600	1686	2091	2298	2526	2526
Guarantee Trust Life Ins. Co. (Form # 90422) 1275 Milwaukee Glenview, IL 60025 (312) 699-0600	1281	1412	1500	1564	1640
Combined Ins. Co. (Form # 14963) 123 N. Wacker Dr. Chicago, IL 60606 (312) 701-3833	1850	2204	2490	2490	2490
Medico Life Ins. (Form # ML3950(MN)) 1515 S. 75th St. Omaha, NE 68124 (402) 391-6900	1417	1579	1760	1961	1961
Mutual Protective Insurance Co. (Form # MP3950(MN)) 1515 S. 75th St. Omaha, NE 68124 (402) 391-6900	1417	1579	1760	1961	1961

COST COMPARISON TABLES

"EXTENDED BASIC" RATES (continued)
Both Male and Female by Age

Company	65	70	75	80	85
American Family Life Assurance Co. of Columbus (Form # A-19000-6) 1932 Wynnton Rd. Columbus, GA 31999	1125	1353	1505	1581	1581
Physicians Mutual Ins. Co. (Form # P117 - Extended Basic) 2600 Dodge Omaha, NE 68131 (402) 633-1000	1436	1574	1574	1680	1680

This Rate Chart was prepared on January 24, 1990 and contains companies that had rates filed on this date.

X. WHAT ABOUT HMOs?

This guide covers medigap policies issued by insurance companies and Blue Cross and Blue Shield of Minnesota which are regulated by the Minnesota Commerce Department. Health Maintenance Organizations (HMOs) are regulated by the Minnesota Department of Health (717 S.E. Delaware Street, P.O. Box 9441, Minneapolis, Minnesota 55440, phone (612) 623-5365 metro or 1-800-652-9747 for HMO hotline). You may wish to contact the following HMOs to compare supplement offerings:

Physicians Health Plan
5601 Smetana Drive
Minneapolis, MN 55440
PH: 936-1612 (metro)
1-800-542-0487

Share Health Plan
3600 West 80th Street
Bloomington, MN 55431
PH: 830-3111 (metro)
1-800-642-3934

MedCenters Health Plan
AMED Division-Minnesota Center
7760 France Avenue
Bloomington, MN 55435
PH: 897-2222 (metro)
1-800-247-3934

Group Health Plan, Inc.
2829 University Avenue, SE
Minneapolis, MN 55414
PH: (612) 623-1919

Blue Plus
3535 Blue Cross Road
P.O. Box 64179
St. Paul, MN 55164
PH: 456-5080 (metro)
1-800-382-2000

Mayo Health Plan
21 - First Street, SW
Suite 401
Rochester, MN 55902
PH: (507) 284-8643
(collect)

Central Minnesota Group
Health Plan
1245 - 15th Street No.
St. Cloud, MN 55301
PH: (612) 259-7328

First Plan HMO
Fourth Street at 11th Ave.
Two Harbors, MN 55616
PH: (218) 834-3304

XI. FOR ADDITIONAL HELP

THE FOLLOWING NUMBERS ARE PROVIDED TO HELP YOU QUICKLY GAIN ASSISTANCE FROM THE DEPARTMENT OF COMMERCE. YOU MAY WISH TO KEEP THIS LIST WITH OTHER IMPORTANT NUMBER TO REMEMBER.

TOLL FREE NUMBER.....1-800-652-9747

AREA CODE (612)

INSURANCE:
- COMPLAINTS.....296-2488
- EDUCATION.....296-6319
- LICENSING & EXAMS.....296-6319

FINANCIAL EXAMINATION DIVISION.....296-2135

COLLECTION AGENCIES:
- COMPLAINTS.....296-2488
- LICENSING.....296-6319

REAL ESTATE:
- COMPLAINTS.....296-2488
- EDUCATION.....296-6319
- LICENSING & EXAMS.....296-6319

SECURITIES:
- COMPLAINTS.....296-2488
- FRANCHISES.....296-6328
- LICENSING.....296-2283
- SUBDIVIDED LAND.....296-2990

UNCLAIMED PROPERTY.....296-2568

MINNESOTA SENIOR FEDERATION AND
METROPOLITAN SENIOR FEDERATION.....642-1398
TOLL FREE NUMBER.....1-800-365-8765

MINNESOTA BOARD ON AGING.....296-2770
TOLL FREE NUMBER.....1-800-652-9747

LEGAL SERVICES OFFICES (Counties Served)

Albert Lea (Rice, Steele, Mower, Freeborn).....507-377-2831
Cambridge (Pine, Kanabec, Isanti, Mille Lacs,
Chisago, Anoka).....612-689-2849
Toll Free.....1-800-622-7772
Cass Lake (Leech Lake, White Earth and
Red Lake Reservations) (not counties).....218-335-2223
Duluth (St. Louis, Cook, Lake, Koochiching,
Itasca, Carlton, Aitkin).....218-726-4800
Toll Free.....1-800-622-7266
Little Falls (Morrison, Todd).....612-632-5431
Toll Free.....1-800-622-7774
Mankato (McLeod, Blue Earth, Waseca, Sibley,
Faribault, Watonwan, Nicollet, LeSueur,
Martin and Brown).....507-388-8436
MINNEAPOLIS, DOWNTOWN (Hennepin).....612-332-1441
TTY for Hearing Disabled.....612-332-4668
Moorhead (Cass, Clay, Becker, Otter Tail, Wilkin,
Traverse, Grant, Douglas, Pope, Stevens, Wadena,
Hubbard, Clearwater, Mahnomen, Norman, Polk, Red Lake,
Pennington, Beltrami, Lake of the Woods, Roseau
Marshall, Kittson).....218-233-8585
Toll Free.....1-800-452-3625
St. Cloud (Stearns, Benton, Sherburne, Wright).....612-253-0121
Toll Free.....1-800-622-7773
St. Paul (Ramsey, Washington, Dakota).....612-224-7301
Willmar (Meeker, Renville, Big Stone, Chippewa,
Kandiyohi, Lyon, Lincoln, Yellow Medicine, Swift,
Lac Qui Parle).....612-235-9600
Toll Free.....1-800-622-4011
Winona (Dodge, Goodhue, Fillmore, Houston, Olmsted,
Wabasha, Winona).....507-454-6660
Toll Free.....1-800-372-8168

Chairman STARK. Thank you very much. I must say that the greatest merger in the world would be Minnesota and Wisconsin. Imagining the LaFollettes and the Fraziers and the Humphreys of the world all coming together to pass the greatest social legislation that this country has ever seen.

That is certainly not to denigrate the great State of Missouri, and what is has done. But what, I guess, I'd like to talk about with all of you is that we are in the same boat. There is a difference, and I have this sneaking feeling that it is only a question of protecting one's turf. I rather have a suspicion that I am going to have less trouble with the insurance commissioners of the United States than I am with Chairman Dingell, whose Committee on Energy and Commerce has jurisdiction over regulating insurance. I should think that you and I would get along a whole lot better than we do. I want to compliment Mr. Borman. Your appointed, is that correct, Mr. Borman?

Mr. BORMAN. Yes, sir.

Chairman STARK. I have just been looking at your cost comparison. Is this all-inclusive? What I'm reading here is that you have got 10 companies who are writing a basic policy, and each one of those policies is identical as to form, format, and benefits. Is that right?

Mr. BORMAN. Yes, yes.

Chairman STARK. OK, so if I'm buying a basic policy for my mother, I can tell right away that if she is in her eighties, the costs run from a low of $261 to a high of $579, and an average of $490, and I can rest fairly comfortably saying that I can save her $318, with exactly the same coverage, if I follow this chart?

Mr. BORMAN. The coverage is identical.

Chairman STARK. Have those that are listed as high, including one from the great State of California—have they complained a lot about being listed here?

Mr. BORMAN. No—I mean, when I issued the report, I anticipated that kind of response, but I haven't received it. In fact, several of the higher end companies have voluntarily lowered their rates.

Chairman STARK. Don't you both see that what we are trying to do here with our Federal legislation, is to find some way in which consumers can easily compare, with some confidence, the costs of equivalent coverage?

Ms. OLSON. Absolutely, Mr. Chairman.

Chairman STARK. OK, so we are all in accord.

Now, let's go to where we—as Mr. Pickle would say—split the blanket.

Mr. Borman, in your job you regulate the sale of securities in the State of Minnesota?

Mr. BORMAN. Yes, sir.

Chairman STARK. You regulate the sale of insurance and the licensing of securities agents and life insurance agents, and casualty agents?

Mr. BORMAN. Yes, sir.

Chairman STARK. And real estate—does that come under you?

Mr. BORMAN. Yes, sir.

Chairman STARK. You license real estate brokers and agents?

Mr. BORMAN. Yes, sir.

Chairman STARK. Do you regulate insurance companies, banks?

Mr. BORMAN. I regulate the banks, chartered banks.

Chairman STARK. Savings and loans?

Mr. BORMAN. No—well, yes. We don't have any in Minnesota.

Chairman STARK. They all went broke? You don't have any State charters?

Mr. BORMAN. We do not have any State charters.

Chairman STARK. So you jumped clear? You don't have——

Mr. BORMAN. We have State chartered commercial banks. We have no State chartered savings and loans.

Chairman STARK. Well, OK, then. You basically have some institutions, Federal savings and loans, over which you have no control, really?

Mr. BORMAN. That is true.

Chairman STARK. All done by the Federal Government?

Mr. BORMAN. Yes.

Chairman STARK. Then you have securities where you probably have to issue blue sky statements?

Mr. BORMAN. Correct.

Chairman STARK. I would presume that you are about as tough as Wisconsin, which I always heard was the toughest of all the blue skyers, but there are also parallel, sometimes conflicting, sometimes stringent—SEC requirements, are there not?

Mr. BORMAN. Yes.

Chairman STARK. Sometimes both you and the SEC are after the same bad guys, right?

Mr. BORMAN. Yes.

Chairman STARK. Is that a problem for you?

Mr. BORMAN. The commercial bar would say it is a problem. I don't know that it is a problem for us.

Chairman STARK. What I am hearing is that many State insurance commissioners don't want the Federal Government in this area of regulation, and I'm trying to suggest that where you deal with both, you deal with some—you have financial institutions that are completely federally regulated, you have some that have no Federal regulation, insurance companies, for example, and you have some where you share.

Now, is there any clear cut pattern which would make your enforcement easier, or more difficult, or is there any pattern of more or less consumer fraud, depending on who regulates whom?

Mr. BORMAN. No. I think the problems that I have, and I must say that I'm still formulating a position on this, because I have been in this job a total of 40 days. [Laughter.]

Chairman STARK. There goes my star witness. Well, I want you back.

Mr. BORMAN. I think that what I found when we issued the study; what I found after the repeal of catastrophic, was that seniors didn't know what the law was, and I think there is a real risk here that if you change the law again, there will be more confusion, and I think the 10 or 15 percent of the—or let's just say, the bad actors—in the industry that we are trying to regulate prey on that confusion, and I think you have to be concerned about that.

The Baucus amendment got everyone going. I think that was positive legislation, but right now, you have a situation where I do

not believe seniors know what coverages are available, how much they can pay for those, and that's why we thought this was so important.

Chairman STARK. I like yours better than mine, to be honest with you. I mean, it is simpler, and more clearcut.

Mr. BORMAN. Well, let me, if I may, just make one other point. There has been a concern raised by a number of people about enforcement. My biggest concern about turning this matter over to Health and Human Services is whether there is going to be enough money to enforce it, and if that isn't a part of this, and there isn't a commitment made for those dollars, then you might as well forget it.

Chairman STARK. Well, I understand that it is one of the reasons, and it is one of the strange phenomena of what we call jurisdiction. This committee's only handle on enforcement would be through the Tax Code, and boy, that's quick and dirty relative to other types of Federal enforcement.

Just in general, the IRS guys don't mess around. Your house, car, business, and pet hunting dog can be gone before you get home from filing bankruptcy, and they are quick, and justice is swift. I guess the only thing that we have been looking at there, where we think we have a real advantage, is that we could, in fact, simply and easily compile the statistics.

If a person had to register a Social Security number, as against a policy number, we would soon know if somebody had two. Now, who acts on that? I'm not a lawyer, but who has to prove intent, and go out and do all those things, is a matter of indifference to me. I'm not looking to generate work for the FBI, or the IRS agents, but I do think in some areas, particularly when you are dealing with mail order, particularly where you are dealing with a mobile population, or jurisdictions like we have here, where, you cross the street and you are in Maryland, and you cross another street and you are in Virginia, and you cross the bridge and you are in Washington, D.C. You have to go a long way to get from Minneapolis to the Wisconsin border, and your people may not travel as much, but I think, as we become more mobile, Federal standards, and some help by the Federal Government in collecting the data you can use to enforce, ought to be useful, and I know that there is this horrid fear. All I can say is that it is coming.

For example, at least 12 or 13 out of the 15 commissioners on the Pepper Commission agreed, that we ought to have Federal regulation of health insurance so that there will be no medical underwriting, and no preexisting conditions. My guess is that we will see a few more life insurance companies go broke, which, as far back as I can remember, people have never even conceived of in this country. You never heard of it in the depression. I can give you a litany of the banks that closed in Minneapolis and Milwaukee, but not life insurance companies. Yet, we may see the day when there will be Federal regulation. Although I don't think it will preempt the States, and I have no grandiose scheme to be the first one. This may be the first issue which requires it, but I really think it is coming. When I say coming, I think of 3 years, max, that you are going to see somebody breach that issue of Federal regulation of insurance. All I can guess is that we could do it better together than

we can do it separately. There ought to be some things that we can add to help make your job easier as a State regulator, and that is what I am looking for. There are certainly some things that you can do better and more efficiently, and I just think the Baucus standards, which are voluntary, aren't quite there yet. So Ms. Olson, my question to you is, what is the first area that we are going to work cooperatively in? Is it going to be medigap? Is it going to be health insurance? Life insurance? Where do you see, and how soon, some Federal regulation, and what is going to be the mechanism for our getting together?

Ms. OLSON. Well, Mr. Chairman, the NAIC has not expressed an opinion on the Pepper Commission report, so we have not said——

Chairman STARK. You are probably the only person in the country who hasn't. [Laughter.]

Ms. OLSON. Yes. We have not said what we think of that proposal in health insurance, which is a huge, huge area, but we do think that we have worked cooperatively with the Federal Government for over 10 years in the Medicare supplement area already, so we would not want you to think that we are not cooperative in working with you to address the same goals.

I think Commissioner Borman really emphasized the point that I was trying to make, and that is that your proposal tries to do the same things that we are trying to do. As a matter of fact, a lot of the language that we have just implemented in our consumer protection amendments appears in your bill. We know that we are trying to do the same things, and the only point that I was trying to make is that the funding appears to be lacking. The 6,000 people that are already available and trained in the State insurance departments are helping consumers. They are helping them sort through the morass of paperwork, and the complicated nature of the Medicare program, itself, as well as Medicare supplement insurance. We have been supportive of Senator Pryor's bill, introduced last week, to establish counseling programs for the States that do not have adequate funding for that purpose, and believe that that proposal would assist the States.

Chairman STARK. What can you do to turn off Ed McMahon?

Ms. OLSON. Well, Mr. Chairman, we thought we had turned off Ed McMahon, basically, and a number of States thought that they had. I haven't heard anything recently; nor has the association, that Ed McMahon, or Lorne Greene, has proliferated. The NAIC has adopted amendments, I believe, 2 years, ago——

Chairman STARK. Yes, I think Lorne is dead, isn't he? Who's alive, Danny Thomas is alive and Lorne is dead. You didn't have anything to do with that.

Ms. OLSON. I think that Lorne is dead. Thanks for correcting me.

Chairman STARK. But the residuals go on.

Ms. OLSON. The residuals go on, but I don't think that they have proliferated as much as others.

Chairman STARK. I guess what I am asking is that it seems to me that getting 50 States to get together and agree is a tough job, and particularly, where you have independent, creative, well-meaning regulators, who have to deal with legislators, or Governors, or an electorate, in the case where they are elected. It is tough enough getting any kind of agreement out of 36 legislators on this commit-

tee—to deal with 50 independent commissioners would seem to me to be difficult.

At some point, we are going to move, and I'm never sure where that point is. Generally, it is at a point where the people are so mad, or a columnist or a TV journalist paints up the horror stories, which are anecdotal, and then Members of Congress begin to get postcards; or Jimmy Roosevelt decides that he is going to raise hell, and then neither one of us can stop legislation from changing.

I do appreciate all of the good work that you have done, and the help you have provided. What I'm sensing is that we are very close to getting something done here that is much more comprehensive, and much stricter, than the Baucus standards, but the one stumbling block is this fear of Federal regulation in any area where we have never been, and I wish we could figure out how to get past that. If that were off the table, I have a hunch that we would be able to find something that we could do more quickly.

Maybe I'm wrong. Maybe every insurance commissioner is dreaming of the day that Federal Government regulates insurance companies.

Ms. OLSON. I don't think so.

Chairman STARK. I don't think so either, but it isn't so bad with securities dealers. I bet it helps in a lot of States, and I'm sure I bet it helps to get after the boiler room guys that peddle penny stocks over the telephone in your State. You couldn't get at them if it weren't for the Federal Government.

So I am looking for the way to make this palatable, because I think we will end up doing a better job.

Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman. I served for 20 years in the State legislature, so I take rather seriously efforts made to preempt the States; however, I must tell you that the testimony here today from the GAO and from other witnesses, in fact, from your testimony, indicates that we have a very serious problem on medigap insurance. There is a great deal of confusion out there, there are a lot of duplicate policies being sold, very low loss ratios, and there is need for action.

As I understand it, NAIC adopted new standards at the end of last year. I'm curious as to how many States had already had these regulations in effect prior to the end of 1989, and how many more States have moved to adopt these types of regulations.

Ms. OLSON. Mr. Chairman, a number of States had already implemented the provision on actual loss ratios and the accompanying loss ratio standards, because the NAIC adopted those provisions in 1987, so these are the first years, now, where we are seeing the States having the ability to have the mechanism in place to enforce loss ratios. With respect to some of the other consumer protection amendments, however, the States did not have them in place.

Mr. CARDIN. I was just going to take one. How about the duplicate policies, to prohibit the sale of more than one policy, except under certain circumstances. Have most States, prior to this time, adopted regulations that prohibit duplicate sales?

Ms. OLSON. Mr. Chairman, we conducted a survey about 1½ years ago, and 16 States, we found at that time, had prohibited the sale of more than one policy.

Mr. CARDIN. Now, did you also do any surveys to see how many policyholders in those States, in fact, had duplicate policies?

Ms. OLSON. No, I don't have those figures.

Mr. CARDIN. Can you tell us of any—let's leave Minnesota out for one moment—can you tell what States are doing in an effort to enforce their own regulations? I mean, GAO is reporting to us that you have these regulations in effect in States that prohibit certain practices, that are either confusing or costly to our elderly, but it seems like there has been very poor enforcement of those regulations in many States. Are my observations wrong?

Ms. OLSON. Congressman Cardin, there are abuses occurring. The NAIC does not believe the abuses are rampant. The NAIC believes that the abuses do exist, and the States really are addressing those problems.

We can talk about several different areas. If you would like to talk about duplication——

Mr. CARDIN. Just duplicate policies. I think, and maybe staff can help me as to what GAO's testimony as to the number of people that have more than one policy, but it was 24 percent, is that right?

Chairman STARK. Approximately 24 percent of the people who buy medigap policies have more than one.

Mr. CARDIN. So 24 percent have more than one—are all those individuals located in those other States that don't have regulations governing this? I doubt that.

Ms. OLSON. No, I'm sure not.

Mr. CARDIN. Why haven't the States done a better job in regulating or enforcing the regulations that they have?

Ms. OLSON. Congressman Cardin, I do believe the States are enforcing what they have. On duplication of coverage, the States are pulling licenses, they are suspending licenses, they are fining companies, they are fining agents, they are getting moneys back for consumers, and I know for a fact that it does happen.

Last year, we were asked to provide some examples in response to questions like you are asking, and within 2 days, I had Federal expressed to me administrative actions that were taken against agents in the Medicare supplement area. I came from a State insurance department where I did prosecute agents, and I know that it happens, because I did it. I can't give you figures on exactly how many licenses have been revoked in the last year. If you would want me to try and pull together some figures, I could.

Mr. CARDIN. I would be interested in seeing those figures, but I would also be interested in receiving your observations as to why there is still, in 1990, such a large number of elderly that have duplicate policies, if, in fact, States have held that as an improper practice, and are enforcing their laws. Why do we have such high numbers?

Ms. OLSON. I guess, Mr. Chairman, I am uncertain about the figures, and I'm uncertain whether that 24 percent is a duplication of Medicare supplement policy against Medicare supplement policy. Is that what the statement is, or it other additional health policies, like limited benefit policies, hospital indemnity, cancer policies?

Mr. CARDIN. I assume that it would include the entire gamut, but I would still assume that you will find an extremely high percent-

age of elderly that have duplicate policies, which would be consistent with my observations, and the groups that I have spoken to on this subject, and we had some polling as to how much insurance people have. We always find that they have more policies than they need.

Ms. OLSON. I understand what you are saying. In response to your earlier question, though, about what States are doing, what States had in place, and have had in place for 10 years under Baucus, as well as their own State standards, are that substantial duplication is an offense, and what I am trying to explain is that States do, in fact, and have, in fact, enforced those standards.

Mr. CARDIN. Well, then, I would appreciate you——

Chairman STARK. Would the gentleman yield? Just for the record, it is my understanding that the AARP, as a result of a survey, concluded that 24 percent of the seniors with medigap insurance have two or more policies.

Now, it is also my understanding that those may include disease policies, or indemnity policies. It is my understanding that the Health Insurance Association of America admitted that 15 percent of policyowners have two or more. Now, the other figure that is very disturbing is the AARP's statement that 51 percent of Medicaid beneficiaries purchase medigap. Now, to me, you are dealing here with the poorest of the seniors, and those who least need medigap, or certainly can't afford it. Now, I don't know how big of a number that is; I don't know what percentage of the 32 million Medicare beneficiaries are also on Medicaid, but, I mean, it is a significant number of a population that is exposed.

Mr. CARDIN. I appreciate the clarification, and I think we all admit that there is a problem out there, and I guess it is nice to adopt regulations. It is another thing to enforce those regulations, and I have not seen the priority placed on enforcement that I would have liked to have seen by State regulators, and I would welcome any information that you can make available to me or the committee to show that the States have, in fact, been more actively involved in pursing regulatory abuses by insurers.

Ms. OLSON. We do understand what you are asking, and would be happy to submit information to you.

And Mr. Chairman, the point about the Medicaid eligibility is exactly what we have been concerned about. That's why in our consumer protection amendments we have added questions asking whether an individual is eligible for Medicaid, or is, excuse me, covered by Medicaid, because as an organization, we do not believe it appropriate that a person purchase coverage when they are covered by Medicaid. However, during our discussions, we found that some States actually require the offering to individuals, even if on Medicaid.

[The following was subsequently received:]

NAIC

120 West 12th Street
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Kansas City, Missouri 64105
816-842-3600

816-471-7004 Main Fax
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National
Association
of Insurance
Commissioners

April 23, 1990

Congressman Fortney H. "Pete" Stark
Chairman
Subcommittee on Health
Ways and Means Committee
U. S. House of Representatives
Washington, D.C. 20510

Re: Questions Raised at March 13 Hearing on the Medigap Reform Act of 1990

Dear Congressman Stark:

The NAIC would like to submit this information in response to two questions asked at the March 13 hearing of the Subcommittee on Health. **First, Congressman Levin asked why state insurance departments such as Michigan are unable to assist policyholders with complaints on policies marketed by companies domiciled outside the state.**

Michigan does in fact assist policyholders with complaints on policies marketed by companies outside the state, but Michigan does not require a master policy issued to a group located outside Michigan to contain the minimum benefits required under Michigan law. For further information, please contact Jean Carlson at the Michigan Insurance Department at (517) 373-0223.

Second, Congressman Cardin inquired how insurance regulators are addressing the 24% of senior citizens surveyed by AARP which hold more than one policy.

States are obligated under existing laws, both state and federal, to make sure that Medicare supplement coverage is not substantially duplicative of the coverage an individual already holds. The federal language originated in the "Baucus" amendment. That standard has a loophole which says that duplicate coverage is prohibited unless the duplicate coverage will pay benefits. The NAIC has encouraged the closing of this loophole.

The 24% figure represented in the AARP survey, however, includes individuals who hold other types of policies in addition to Medicare supplement, such as hospital indemnity or other limited benefit coverage. The recently adopted NAIC standard on this issue prohibits the sale of more than one Medicare supplement policy unless the additional policy's coverage, when combined with

other health insurance, amounts to coverage of more than 100% of the person's actual medical expenses. This new standard will be adopted by states before the end of the year.

We also would like to refer you to the percentage of consumer complaints which relate to Medicare supplement insurance in the following states:

State	% of Total Consumer Complaints Involve Medigap Policies
Texas	13%
Wisconsin	12
Utah	10
Idaho	Below 10%
Kansas	Below 10%
Kentucky	Below 10%
Minnesota	Below 10%
New Jersey	Below 10%
North Dakota	Below 10%
Rhode Island	Below 10%

These figures were compiled by the AARP in late 1989 in conjunction with NAIC.

I hope that this information is helpful. Please let me know if I can provide additional information.

Sincerely,

Carole J. Olson

Carole J. Olson
Assistant to the Executive Vice President

Enclosure

cc: Comm. Earl R. Pomeroy

Chairman STARK. The confusion is rampant. Some States actually buy Medicare for Medicaid beneficiaries, and so the beneficiary may very well think that they are covered by Medicare.

I would like to ask unanimous consent to include, printed in the record, pages 24 and 25, and any supporting details, of the Minnesota Department of Commerce's cost comparison study. The Chair would like it in there as an example of a simple-to-read, easy-to-understand, cost comparison of medigap policies with identical benefits. The Chair would suggest that it passes the simplicity test by virtue of the fact that he can understand it.

[The entire report appears following Mr. Bormnan's prepared statement.]

Mr. CARDIN. Mr. Chairman.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. If you would just yield for one more moment, I want the record to be clear that my questioning on the duplicate coverage is not meant to be exclusive to that. There are many other problems that have been brought out today, so any information that you could provide, particularly on the ease of a consumer to make an intelligent decision as to what plan is best would be very useful.

Chairman STARK. I really want to thank the panel, and again, to suggest to you that I just know, as sure as I sit here, that we are going to be back meeting again in the not too distant future, on health insurance in general, and dealing with changes, for instance, in disallowing medical underwriting, and disallowing the withholding of insurance for preexisting conditions, which I doubt that we can introduce nationwide without Federal legislation.

There is some pressure building for that, and so I would encourage the State commissioners to begin to think of how we can do these things together. I think we will do it more quickly, and more efficiently, and let us help with what we can do best, and let's cede to you those areas in which you are far more efficient. I want to thank you both for being here, and I appreciate your testimony.

Ms. OLSON. Thank you, Mr. Chairman.

Mr. BORMAN. Thank you.

Chairman STARK. The committee is adjourned.

[Whereupon, at 1:21 p.m., the subcommittee adjourned.]

[Submissions for the record follow:]

STATEMENT OF
MARTHA McSTEEN
PRESIDENT
NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

I am Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. The organization has no direct pecuniary involvement in the Medigap insurance industry, but as an organization representing about five million seniors, we are deeply concerned about the increases in Medigap policy premiums. Not only are we concerned about the erratic, and in some states dramatic, premium increases, we also must guard against some in the industry who might use the repeal of the catastrophic legislation as an opportunity to sell new and more expensive policies.

In an effort to help our members find their way through the Medigap maze, we have launched an educational campaign. We have developed an easy-to-use Medigap policy comparison chart which we plan to mail to our members free of charge. We have written a column which will appear in local newspapers across the country and we are working with the radio and TV media to advise seniors to seek insurance counseling before switching or upgrading their policies.

A fair share of blame for the dramatic increases in Medigap premiums rests with this nation's continuing inability to curb medical inflation. This has caused all other health insurance rates to increase. Unchecked, medical inflation is undermining our public and private health insurance systems. For example, significant cost underestimates helped erode Congressional support for the catastrophic legislation. The underlying problem of medical inflation must be addressed as we look towards reforming our medical system.

We understand that some insurance companies have sought Medigap rate increases of between 15 and 70 percent. These increases are similar to increases in 1989. According to a state-by-state survey released by the House Select Committee on Aging on November 2, 1989, increases in 1989 ranged from 10 percent in Massachusetts to 133 percent in Arizona. Well over half of the responding states indicated that Medigap prices increased up to 25 percent or more. While we were told by the industry that increases would have been worse had full hospitalization not been covered by Medicare in 1989, beneficiaries never saw the benefit of catastrophic legislation reflected in Medigap premiums. While some of the increase this year is due to repeal of catastrophic, repeal of catastrophic is only a one time factor.

While some degree of variability in rate increases is to be expected, it is impossible for consumers to ascertain what premium increase is justified and what is not. States vary considerably in their scrutiny of rate increases. Some states allow insurance rates to go up without prior approval. According to the Select Committee on Aging survey, two-thirds of the surveyed states do not require changes in rates for group Medigap insurance to be approved before going into effect. Over a third of the states do not require group policies to file their rates and rate changes with the state. And several states, including Alabama and the District of Columbia, do not require that rate changes - whether individual or group - be filed at all. Even in states that require a review before rate increases go into effect, the process varies widely. Some states conduct paper reviews, while a few have public hearings. The consumer tends to fare considerably better in states that have a thorough review process. Maryland, for example, cut in half the rate increase requested by Blue Shield after an extensive hearing and review process. Clearly, a more comprehensive and uniform process to scrutinize rate increases is called for.

The National Committee supports a strengthening and expansion of the 1980 Baucus amendment to the Medicare law governing Medigap policies. Rather than to serve as guidelines, it should be mandatory that Medigap insurance policies meet the requirements of the Baucus amendment.

Further, each state should be required to set up a formal review process before accepting rate increases above Medicare inflation rates. Consumers should be provided an opportunity to be heard during a public hearing process and be able to request in writing a justification of rate increases.

In view of the GAO findings* that the suggested loss ratio of 60 percent or more for individual policies is often not adhered to among commercial insurance companies, the National Committee urges a tightening of the Baucus language. Standards should be set determining for what time period the loss ratio should be calculated and what the loss ratio should be. We would also support efforts to raise the minimum loss ratios for individual and group policies.

For many people, insurance policies and the language associated with insurance coverage are confusing. Private insurance is not unique in this regard; unfortunately the same is true for the Medicare program. It is complex and baffling to many seniors. Until we develop more streamlined systems, we have a responsibility to fund insurance counseling programs to assist seniors through the system. Some states have excellent programs that can be used as models. A small percentage of Medicare dollars matched by state dollars could be used for this purpose.

The complexity of the Medicare program, its billing and reimbursement process, and the interfacing with private, supplemental insurance is emotionally and monetarily costly to most senior Americans. The National Committee believes that it is imperative that we simplify the process of billing and reimbursement and that educational materials be developed by the government, the insurance industry and consumer groups. The wide distribution of such materials allows intelligent decisions to be made concerning insurance needs.

The National Committee certainly believes that there is a strong role for private health insurance in this country. However, there is also an obvious need for further consumer education and protection.

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* GAO testimony, April 6, 1989, before the U.S. House of Representatives.

STATEMENT OF GERALD S. PARKER
TO
THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS

ON

MEDICARE SUPPLEMENT POLICIES

March 13, 1990

My name is Gerald S. Parker. I am a resident of Old Greenwich, Connecticut. I am testifying on my own behalf as a citizen, because I have an extensive background in Medicare supplement insurance. I represent no organization.

As to my qualifications on this subject, I organized the health insurance operations of The Guardian Life Insurance Company of America in 1951 and headed it for 30 years, retiring as vice-president at the end of 1981. I designed the first Medicare supplement policy ever offered that truly supplemented Medicare's benefits. I had it approved in all states and introduced it for sale on July 1, 1966, the day Title XVIII became effective.

During the 1980s, I testified before your Committee on several occasions on behalf of the Health Insurance Association of America and before the Senate Finance Committee. I served on the H.I.A.A.'s Committee on Medicare Supplements and on the Industry Advisory Committee to the National Association of Insurance Commissioners' Committee on Medicare Supplements. I was involved with the "Baucus Amendment." After retiring from The Guardian Life, I operated a consulting business for four years. In 1985 and 1986, I served on the Commission on the Evaluation of Pain appointed by the Secretary of Health and Human Services at the direction of the Congress pursuant to Public Law 98-460.

At present, I am involved with helping seniors in Greenwich, Connecticut make sound decisions on their health insurance and long term care insurance and in training other volunteers to do this also. At present, we have about a dozen regular volunteer counselors. This program is sponsored by our Commission on Aging and the Family Center, a private social service agency.

1. Loss Ratios.

Because loss expenses have been rising at an inconsistently variable (though consistently rapid) rate, considerable variation in loss ratios from year to year is to be expected. But when an insurer's loss ratios averaged over a period of five years have been significantly lower than the Baucus standards, it should be denied additional rate increases until its five year loss ratios have reached the minimums.

The minimum allowable loss ratio on group insurance is higher than on individual policies. This is quite proper for employer - employee and similar plans where the advantages of bulk billing and administration exist. However, most people over 65 are no longer in such groups, except where employers furnish the coverage to their retirees.

Many group plans are really simply membership associations in which each individual member must be solicited, billed, and have his claims paid individually, and in these groups administrative expenses cannot be significantly less than on individual policies. A 75% minimum loss ratio is too high for such plans.

There will be pressure to raise the allowable loss ratio on individual policies. Any minimum over 60%, or perhaps 65%, would be unwise as it would seriously impact the availability of coverage to senior citizens. Already, many good insurance agents who can make a living ethically tend to avoid soliciting Medicare supplement policies, because the service requirements to policyholders are very high due to their high ages and frequent use

of benefits while commissions are significantly lower than on other lines of business.

2. Abuses

In the 1980s, the abuses often cited tended to be concentrated among agents of a handful of companies that specialized in these coverages and who had to sell high volumes and avoid service as much as possible in order to scratch a living. Most states now have statutes requiring questions in insurance applications seeking information on existing insurance, prohibit knowing duplication, and require notification of a replaced carrier. Only if a dishonest agent fails to record the answer or doesn't ask the question will duplicate coverage be sold.

Generally, all the states have adequate laws and regulations governing the behavior of agents. The problem is enforcement, and a federal statute would have the same problem. It would be useless to enact a federal statute without providing for enforcement; and since knowledge of violations would still depend pretty much on complaints by citizens, it is hard to see how any improvement could be expected.

Our volunteer counselors have not reported any abuses in this area among over 125 seniors counseled in about a year. We suspect that the Connecticut Insurance Department has not admitted the trouble maker companies. The cases of duplicate coverage we have run into have not arisen from agent pressure, but from policyholder ignorance and fear. Almost all of them have involved the carrying of both AARP and Blue Cross/Blue Shield Medicare supplement policies, and both of these are direct response writers. Agents are not involved.

3. Coverage Problems and Recommendations

A major problem for seniors is the difference between what physicians actually charge and what Medicare allows under Part B. In the southwestern Connecticut area, Medicare generally allows some 55% to 65% of what physicians charge. As Medicare pays 80% of that, the patient is out of pocket about half of the bill.

In this area, only two insurers offer an optional benefit that pays the difference between what Medicare actually pays under Part B and the insurers' definitions of "usual and customary," which in my experience is generally 100% of the bill. Both are excellent carriers (Bankers Life & Casualty Company and Mutual of Omaha Insurance Company) and have good reputations for claim service. But why should not most carriers offer this option?

Too many insurers insist that the Part A deductible be covered. This is extremely expensive. Only one company operating in our area makes it an option. The extra annual premium to cover that Part A deductible this year runs from $199.30 to $327.16 on a basic Medicare supplement policy, depending on issue age. That's a lot to pay for a $592 loss! Put another way, it increases the premium for the basic policy about 65%. People should have the option of paying the deductibles out of pocket.

The Blue Cross plans will oppose this, but other insurers should not. When I was last active in 1981, several states required the coverage of the initial deductibles on Parts A and B. It's my belief that the present N.A.I.C. minimum standards only require that, if any part of a deductible is covered, all of it must be. If any states still require the coverage of the deductibles, they should be pressured to discontinue such requirements.

Our Greenwich volunteer counselors have been highly effective. It would be desirable for other communities to establish similar groups. New Jersey has long had such a problem under the wing of its Insurance Department. They were helpful to us in getting started.